Child and Family Services Reviews

Statewide Assessment
With Built-In Instructions

Children's Bureau
Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

Introduction

The child and family services reviews, regulated by the Administration for Children and Families (ACF) and facilitated by the Social Security Act Amendments of 1994, are designed to support a stronger Federal-State partnership in improving the outcomes of services to children and families. The review strategy seeks to achieve this by linking review of State child and family services to joint planning and technical assistance and emphasizing continuous improvement in State child welfare systems. The reviews include three outcome domains that cover the continuum of child welfare services: safety, permanency, and child and family well-being, as well as an examination of State and local agency characteristics that affect the achievement of positive outcomes.

This instrument, "Child and Family Services Reviews: Statewide Assessment," is completed in the first stage of the review process by the State, in consultation with State representatives external to the State agency and ACF Regional and Central Office staff. The second stage of the review process is an onsite review, conducted by a team of State and Federal representatives, peer reviewers, and external reviewers. "Child and Family Services Reviews: Onsite Review Instrument" is used for the onsite case reviews, and the Stakeholder Interview Guide is used for the onsite stakeholder interviews. Information from the statewide assessment and the onsite review is used to make determinations about the States' substantial conformity with the State plan and other program requirements under review.

Section I of the statewide assessment requests general information about the State agency. Section II focuses on State child welfare agency characteristics and requires narrative responses on systemic factors, based on data to the extent available to the State. Section III includes data profiles for the safety and permanency outcomes, including the statewide aggregate data indicators used to determine substantial conformity. Section IV requires a narrative assessment of the outcome areas based on the data profiles in section III. Section V requires the State to assess its strengths and needs and identify issues and locations for further examination through the onsite review. The data profiles in section III are based on the Adoption Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS) data that are provided by the ACF to the State when the State initiates the statewide assessment.

The statewide assessment must be completed in collaboration with State representatives who are not staff of the State agency, pursuant to 45 Code of Federal Regulation (CFR) 1355.33 (b). Those individuals should represent the sources of consultation required of the State in developing its title IV-B State plan. The names of external representatives who participated in developing the statewide assessment must be listed in section V of the instrument.

The instrument is available electronically through the Children's Bureau Web site at
<www.acf.dhhs.gov/programs/cb>.

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104–13)

Public reporting burden for this collection of information is estimated to average 240 hours for the initial review and 120 hours
for subsequent reviews. This estimate includes the time for reviewing instructions, completing the assessment, and reviewing the
collection of information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a
currently valid OMB control number.

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Statewide Assessment Instrument

Section I - General Information

Name of State Agency
RHODE ISLAND DEPARTMENT OF CHILDREN, YOUTH & FAMILIES

Period Under Review
Federal Fiscal Year for Onsite Review Sample _____ Period of AFCARS Data _____ Period of NCANDS Data (or other approved source; please specify alternative data source) _____

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INSTRUCTION

The Statewide Assessment is the first phase of the review process. It provides States with the opportunity to examine data relating to their programs and to consider the data in light of programmatic goals and outcomes for children and families served by the State. The Statewide Assessment requires State review team members to consider the State's success in helping children and families achieve positive outcomes in the areas of safety, permanency, and well-being. Moreover, through the Statewide Assessment process, a State can identify areas in which it is performing well and areas that need further examination through the onsite review.

Statewide Assessment Process

States should use the following steps in completing the Statewide Assessment:

1. Identify key agency staff and community representatives (such as those serving on the title IV-B planning committee) to serve on the State review team and to participate in the Statewide Assessment. (Agency staff should be selected on the basis of their expertise, for example, in quality assurance or foster care. External partners should be selected with a focus on ensuring representation of organizations and agencies with an array of service delivery mechanisms and perspectives on the State agency's practices.)
2. Examine existing State documents that provide information about the State agency during the period under review that might be useful in completing the Statewide Assessment. (The review team, for example, would look for descriptive and evaluative data in the title IV-B plan, management reports, studies, commission reports, and task force findings.)

3. Receive and analyze the data provided by the Children's Bureau through the Administration for Children and Families Regional Office (including consulting with non-review team members, as appropriate):

    $ Review the statewide aggregate data related to each outcome in the Onsite Review Instrument and identify areas of strength or the need for further examination during the onsite review, and the reason(s) for the status of the data indicators.

    $ Compare the State's performance on statewide aggregate data with the national standards, where applicable. States will need to address indicators that fall below the national standards in a Program Improvement Plan. It is important therefore for States to identify the factors affecting these indicators.

4. Consult with external stakeholders.

    The State should consult with stakeholders regarding data indicators. For example, the team conducting the Statewide Assessment might talk with caseworkers and foster parents about the number of placement settings experienced by children. The States also will consult with stakeholders to obtain information to complete the narrative sections of the Statewide Assessment on systemic factors.

    States are encouraged to use a variety of approaches in consulting with external stakeholders. The agency might gather information, for example, through the following:

    $ Holding focus groups with stakeholders or consumer groups

    $ Conducting surveys

    $ Hosting joint planning forums within the State

    $ Developing other strategies for linking the Statewide Assessment to the ongoing consultation process used for title IV-B planning

    The exploratory issues provided on the following Statewide Assessment With Built-In Instructions may be used to analyze key issues and to consult with stakeholders

regarding the systemic factors under review. The questions are intended to provide States with guidance for completing the assessment and are not intended to impose additional requirements on the States.   States also may access technical assistance from the Federal Government in planning for and conducting the Statewide Assessment.

Format of the Statewide Assessment

A completed Statewide Assessment should be approximately 75–85 pages. States should use the Statewide Assessment form provided and avoid attaching other documents, whenever possible. The Statewide Assessment should contain the following:

$ Brief description of the agency structure and programs

$ Information about the relationship between the data and the State's practices and policies

$ Information on the effectiveness of the systemic factor being reviewed

$ State data profile

For each Systemic Factor, the State should provide the following:

$ Overview of the system under review, including the requirements, structure, law, policy, and functions

$ Information on how well the systems work, including strengths, gaps, needs, and usefulness

$ Information on how the State's functioning in each systemic area affects the outcomes of safety, permanence, and well-being

$ Information on ongoing processes or mechanisms, such as the State's quality assurance system, that routinely examine the effectiveness of the systemic factor and promote continuous improvement in that area

It is important that completed Statewide Assessments clearly show an analysis of the relationship between State data and practice, and the quality/effectiveness of the system under review. If a State's data show that children have frequent re-entries into care following reunification, for example, the State should use the Statewide Assessment process to explore, and then document, the possible reasons that this is occurring. To do so, the State might examine the availability, accessibility, and quality of services to support family reunification. Or, if the State's data show that children wait long periods for permanent placements, the State might explore the case review system and its effectiveness in moving children to permanency in a timely manner.

Section II - Systemic Factors

A. Statewide Information System Capacity

> 1. Discuss how effectively the State is able to meet the State plan requirement that it operates a Statewide information system that can determine the status, demographics, location, and goals for all children in foster care in the State. In responding, consider the accessibility of this information to State managers and local staff and the usefulness of the information in carrying out the agency's responsibilities.

RICHIST (Rhode Island Children's Information System)

The Rhode Island Department of Children, Youth and Families implemented a Statewide Automated Child Welfare Information System (SACWIS) in August 1997. The Rhode Island Children's Information System, called RICHIST, contains all of the functionality required by federal regulations, which includes case management, staff management, financial management, provider management and policy and procedure management functions. It establishes an electronic case record, eliminating much of the paperwork. As continuous quality improvement work is ongoing with the RICHIST system, the database is becoming a valuable resource for line staff to easily access information and identify the type of services that families need. This information includes child and family demographics, child welfare status, case plan goals, and child placement information, as well as legal, medical and educational information. In May 2001, the RICHIST system was recognized as one of four child welfare state project systems in the country to meet federal compliance standards for SACWIS operation.

RICHIST is available to over 700 of the Department's employees including administrators, supervisors, and workers across the Department. Staff in all areas of the Department, including investigators, social caseworkers, probation counselors, clinical social workers and supervisors are expected to complete their work in RICHIST. Any information entered in RICHIST is immediately viewable by any worker in the Department that has the security to view the information. The Office of the Child Advocate has access to information stored in the RICHIST system as well.

Management Reports/Tools

The Department recognizes the value and necessity of information for effective planning. As the technology of information gathering and database development has evolved, Department administrators have identified the need for more detailed and accurate information capacity as a top priority. The Department is moving forward to further enhance data extraction capability in order to use information more effectively for future-oriented, fact-based planning responsibilities. The Child Welfare Training Institute has conducted training based upon work developed by the University of Southern Maine to train managers and administrators to make better use of data.

The Department has developed over twenty-four (24) management reports from data entered in RICHIST. These reports provide useful information for management and supervisors regarding

- child demographic information,

- living arrangements,

- a listing of children in care for 15 of the last 22 months,

- daily census for the Rhode Island Training School,

- caseload statistics for Family Service units, and

- Child Protective Services reports detailed by worker regarding the status of assigned investigations.

At the end of each month, a fact sheet is generated providing point in time summary information pertaining to the various units/divisions within the Department.

Supervisors also have an online application to the AFCARS Exception Report that allows supervisors or administrators to generate exception reports whenever AFCARS related data are entered incorrectly into RICHIST. This allows for effective correction procedures to ensure data accuracy. The system also generates ticklers that provide workers and supervisors information regarding overdue case plans and foster care reassessments; and, more recently, a new module to track permanency hearings has been developed and implemented.

The office of Management and Budgeting has access to a number of reports regarding

- purchase of service placements,

- IV-E eligibility and penetration rates, and

- Title XIX reimbursement reports.

Additionally, the Department received a grant two years ago from the US Administration for Children and Families to develop a Child Welfare Data Analytic Center. Through this initiative, we are working with the Consultation Center at Yale University in New Haven, Connecticut, to further develop and enhance our data analytical capability. Yale University is working with the Department on a number of evaluation and outcome focused initiatives, including the following:

- research into the nature of repeat maltreatment and rates of re-entry into foster care;

- reporting on performance measures for all of the contracted programs;

- assisting with the evaluation of our community-based Children's Intensive Service program which is an outpatient mental health service for serious emotionally disturbed children; and

- creating a longitudinal study and analysis on the Department's child welfare data that is also used for the AFCARS reports.

Significant RICHIST Enhancements

Since its inception in 1997, quite a lot has been done to promote staff competency with RICHIST. The capacity of RICHIST itself is continuously being fine-tuned to make the system more useful to line staff entering data; however, there continues to be a need for more detailed, case specific information to be available in report format back for workers and supervisors. Still, over the past six years, RICHIST changes to improve the ease of data entry have been especially helpful in the areas of:

- case activity notes,
- child protective service reports,
- investigations,
- case profile narratives, and
- case plans.

The Administrative Review process has been entirely redesigned since the CFSR 2000 pilot. With the creation of a distinct module in RICHIST, new functionality was added to the administrative review process allowing the reviewer to create the RICHIST data during the actual meeting. The establishment of an "ARU Meeting" module now provides a method to retrieve foster parents as an invitee to the meeting and also automatically generates notification letters to foster parents.

Since the pilot review in 2000, a number of RICHIST screens and forms have been improved for usability. The Child Protective Service (CPS) report and investigation windows were redesigned as a result of the SACWIS review. The search function has been enhanced to make it easier for staff to locate case and provider information. Security changes have been made in response to enhancements and changes to other modules. Functionality has been added to limit access to hidden cases.

Feedback from casework and supervisory staff in the Family Service Units (FSU) report that the system is working very well and credit MIS with numerous revisions from the start to make the system more user friendly. Case activity notes are easier to enter and now can be arranged in order, as case plan information and adoption information pre-fills saving time for workers. Workers are more up to date with entering information allowing FSU and Child Protective Services to immediately access up to date information. With more information available on a single screen, the system overall is more user friendly.

Knowledgeable help desk staff and computer technicians are now available in each regional office which allows workers to get assistance with any question immediately. Computer problems not related to RICHIST are also solved immediately.

In some circumstances, community partners have noted that it seems easier for workers making phone referrals because provider and service information is more easily accessible in RICHIST.

Department Initiatives through MIS
In recent years, as each department and office of Government has begun to enhance its information technology and better understand the inter-relatedness of the data needs, there has

been a steady movement toward developing an interlinking system of databases for those populations commonly served within the public sector. The Department of Children, Youth and Families is involved in a number of these initiatives across systems as identified below:

DCYF and the Department of Human Services (DHS), the state welfare agency, have implemented a two-part interface. Active children in RICHIST are matched with children in the Title IV-A system at DHS. Once matched, an initial set of data is passed to each system. From this point forward, all changes made in either system are passed to the other on a daily basis via the interface. DCYF sends DHS information on case openings/closings, removals and return of children to their home, changes in demographic or address data, and worker information. DHS sends to DCYF changes in demographic or address data, parent address, Family Independence Program (FIP) status, Medicaid status, and child support enforcement status. Through this interface, SSI and SSA income is passed from DHS to DCYF for an eligible child and duplicate payments under the Title IV-A and Title IV-E programs are avoided as procedure requires a case be closed when opened to the other department. At the present time, this data is not known or available to line staff. Efforts are under way to identify a process for line staff to more readily locate parents through this interface.

DCYF contracts with Placement Solutions to provide utilization reviews (UR) for all children in purchase of service (POS) placements and contracted facilities. This work is also in conjunction with the Yale University Consultation Center. As a result of this collaboration, the Department is provided with analytical data that can be utilized by the DCYF to conduct quality assurance reviews of children in residential facilities. The Department plans to continue the work with Yale to further develop and maintain the Data Analytic Center, and we are now in the process of using the results of their studies to inform case practice in anticipation of improving outcomes for families and children.

The Department has also been working on an interface with the Family Court system to enable staff better access to up-to-date legal information and to avoid duplication of effort when documenting court hearings. This activity is evolutionary, and as the interface is more fully developed, the data exchange process is expected to be reliable between the two systems.

KIDSNET is a data interface between the Department of Health (DOH) and DCYF that is currently in the planning stages. The goal of this interface is to enable the DOH to work with DCYF and foster care providers to ensure that children in substitute care have their medical records up to date and all necessary immunizations and well-child check-ups on schedule.

The Department is also working with the Office of the Attorney General to access online criminal background checks. The details regarding access to this information inter-Departmentally will be the basis of a Memorandum of Agreement.

Another ongoing initiative by all state agency departments that serve children is to develop a common identifier. The creation of a common identifier will allow easier identification in all state systems in order to provide better services for children and families.

Since the pilot review in 2000, the Department has developed a web site and all current daycare providers are listed on the website with the capability to search on a specific provider. Statistics of common interest, including the federal child welfare outcomes, current news, program descriptions, and links to other state agencies are also available through the web site.

Gaps/Areas Needing Improvement

- An AFCARS Review was conducted in June 2003. During this review, staff from the Children's Bureau, Administration for Children and Families (ACF), Region I federal staff, and Office of Information Services (OIS) staff assessed Rhode Island's compliance with AFCARS requirements. The State is currently reviewing the AFCARS report and is developing a corrective action plan.

  > The most significant issue identified during the AFCARS review impacts data quality. The review determined that the State was not accurately reporting those children that had been returned to their own homes while still in the agency's responsibility for care, placement, or supervision. It was also determined that the State was not including special needs child adoptions by private agencies in which there is an adoption subsidy agreement. These findings are helpful overall to the Department's ongoing efforts to resolve data discrepancies. Through the process of developing this state assessment, DCYF representatives have found several areas where there is greater need for clarity and distinction in identifying and reporting on the population being served. The Department also received a list of education/training reminders for supervisors which will result in re-education activities prior to our Program Improvement Plan.

- Children enter the foster care system in Rhode Island because of abuse/neglect, and/or juvenile justice, and/or mental health or developmental disability reasons. Changes in our foster care population are effected by a multitude of factors in each of these disciplines and across disciplines. Currently we report the case opening reason only at the time of intake and it is a complicated process which leads to errors in reporting. It also does not capture changes during our involvement with a youth or family. It is not unusual for a youth to become involved with DCYF because of a delinquent petition, and later find that he/she has been abused or neglected or has a significant mental health problem, etc.

  > Using one month point in time data our MIS Department was able to generate percentages of opening reasons for the purpose of analyzing our data profile. They were able to sort out children/youth opened during that month because they were victims of abuse and/or neglect, and they were able to sort those who came to the Department through our Juvenile Justice division. All mental health, truancy, wayward disobedient, Interstate Compact Placement Contract (ICPC), court studies, etc. were captured in an "other" category. As a result we learned that of the 6,617 children (excluding subsidized adoption) open to the Department:

- 2,550 (38.5%) were open because of abuse/neglect,
- 1,850 (28%) were open to Juvenile Justice and
- 2,217 (33.5%) were open because of "Other."

We also know that 98% of Juvenile Justice youth are aged 13 or older; 23.6% of abuse/neglect openings the youth are aged 13 or older; and, 54.1% of the "Other" category were aged 13 or older. Contained on our list of priority changes to our RICHIST system is a request to improve our ability at intake and throughout the life of a case to more specifically and accurately report the reason(s) for involvement.

In the past six years, there has been a steady commitment to promote the development and continuous quality improvement of the RICHIST system, as well as other information systems across state government. At this time, however, as the momentum has reached such a critical peak with more and more emphasis and excitement placed on data analysis and performance improvement objectives, state government is facing its most severe economic projections:

➢ The DCYF has had to make reductions that are having a significant impact in the Department's ability to meet critical data needs. The MIS Division has experienced a reduction of 50% of the contract staff that supports the RICHIST project. This cut, along with an inability to increase the number of state staff, has had a negative impact upon the ability of MIS to implement major improvements to the system. With their present staff, MIS is only able to maintain the status quo.

➢ The accuracy of information in RICHIST is improving as the system becomes more user friendly and users become more comfortable with the system. However, compliance in using RICHIST is variable throughout the Department, which creates issues between and among the various divisions. The RICHIST system was designed to be more responsive to the needs of the child welfare side of the Department while the other divisions have found the system less well suited to their needs. While the Department is beginning to work with the Training School and Probation to make the system more usable for them, there is little money available to assist with these efforts.

➢ The RICHIST system is not able to assess whether community-based preventive services that are financially supported by the Department are effective, since these services are provided to children and families that are not open to the Department. At present, there is no mechanism for tracking information on services provided to children/youth who are not on active caseloads; therefore, payment information for these services and their effectiveness is not linked in RICHIST to the families receiving services.

➢ As referenced earlier, data entry has become more user friendly for line staff, but data reports for management purposes regarding case specific information are not available at the line level for supervisors and workers.

➢ Online access to resource directories is another area that the Department is trying to acquire. Though some information is available regarding referral sources, at present, staff are not generally able to access a list of DCYF contracted resources online or other community resource directories.

B. Case Review System

> 1. How effectively is the State able to meet the requirement that each child in foster care under the State's placement and care responsibility have a written case plan with all the required elements?

Current Department policy requires that a written initial case plan be completed for each child opened for service, regardless of the reason, by the assigned primary service worker within thirty (30) working days of the case being assigned to a Family Services worker. The case plan is expected to be developed with the family and child, if age appropriate. Other community providers and foster/adoptive parents are expected to participate in certain parts of the process. In the 2000 pilot CFSR, family involvement in the development of case plans and individualized case plans was noted as an area needing improvement. In the Fall of 2001, partially in response to this issue, the Department began its Family Centered Practice initiative.

The case plan is entered into the RICHIST system which prompts the worker when updates are due. The plan must be updated every six months or, it may be modified more frequently if needed.

According to Department policy, case plans for children in placement are reviewed by the Administrative Review Unit in the Department beginning in the sixth month after a child enters care and every six months thereafter while the child remains in care. The Administrative Review Unit monitors the child's case plan for compliance with requirements of the Adoption and Safe Families Act (ASFA), with an emphasis on a family centered approach to case planning and whether or not the case plan was completed within the required timeframe.

In April 2001, the Administrative Review Unit began using a form that reflects ASFA language in its review process. In keeping with the ASFA language format, the ARU officers are able to determine, for example:
- what efforts were made to avoid the removal of children;
- if parents were included in the decision to place their children; and
- whether parents participated in the development of the case plan.

The new review form is narrative-based and was approved by ACF representative Veronica Melendez. The ARU, Child Welfare Training Institute and MIS do want to change the narrative format to make it a data collection tool for the Department, however, this process is currently only in the planning stages.

The Case Plan/Agreement is time limited and goal oriented and identifies the proposed services for the parent(s) and child(ren). It delineates the mutual responsibilities and expectations of the parent(s), the child(ren), and the Department towards reaching the identified permanency goal. The development of the case plan is linked to the family assessment that addresses the strengths and issues of the family and the individual child's needs.

The child's case plan contains the following elements:
- case plan goal,
- objectives and tasks,
- projected date of goal achievement,
- preventative services,
- educational and medical information regarding the child, and
- the visitation plan, if the child is in placement.

For all youth over the age of sixteen (16), the case plan must also include a transitional living plan and independent living skills assessment. RICHIST is programmed to prevent the creation of a case plan for a youth over the age of sixteen (16) without the inclusion of the transitional living plan and independent living skills assessment; however, it is possible to create blank transitional living plans and independent living skills assessments when workers do not have the information to include in these plans.

Department policy also requires that youth, active in Probation who are placed in DCYF care, have a written Case Plan within thirty (30) working days of entering placement. There are currently about 120 youth who are on Probation and are in care, but do not have case plans in place that meet the appropriate requirements. Efforts to move the Department into compliance with this policy have been slow moving, but progressing nonetheless. The case plan has been revised to meet the specific requirements of youth sentenced to probation. Case plan and permanency planning trainings for Probation and Parole counselors are underway. The Administrative Review Unit will review the case plans for these youth.

> 2. How effectively is the State able to meet the case review system requirement that parents of children in foster care participate in developing the child's case plan? In responding, consider their participation in activities such as identifying strengths and needs, determining goals, requesting specific services and evaluating progress related to their children.

The Department in its pilot CFSR identified the need for increased family involvement in case planning and for partnership with the child's community in developing the most effective intervention strategies. This continues to be an area needing improvement although the Department is involved in a number of strategies designed to increase family involvement in case planning.

A voluntary Program Improvement Plan was initiated through our Child and Family Services Plan to include a Family Centered Practice (FCP) demonstration project. The Family-Centered Practice Initiative represents an umbrella under which four (4) core practice changes are integrated. These practices include:

- Building Relationships through Full Disclosure & Strength-Based Assessments
- Family-Driven, Strength-Based Case Plans
- Creative Permanency Planning and Concurrent Planning

- Cross-System Collaboration

Family-Centered Practice is a priority agency-wide reform agenda. Implementation focuses on the following core components:

- Improved assessments, including greater focus on both <u>safety</u> and <u>family strengths</u>
- Comprehensive assessments informing highly individualized case plans and case <u>planning</u> (improved family participation)
- Concurrent planning
- Family Team Meetings (as part of the Administrative Review Unit) - where case plans are developed with families through the FTM within 60 days of opening
- Care Management Teams - regionally-based family centered inter-disciplinary teams that review and decide on children and youth who may require placement in long-term out of home residential care, or are returning home.

The Department has revised its comprehensive family assessment to be more strength-based in its approach to case plans and strategies for increasing family participation in case planning. This was done in concert with the implementation of family-centered practice during an 18-month demonstration phase. The format for the family assessment is being finalized and will be included in RICHIST. Currently the Case Profile Narrative in RICHIST is where one would expect to find the documentation of a comprehensive family assessment on which decision making would rely. The change from the Case Profile Narrative format to a new strength based Family Assessment format is just one means to achieve a strength based, comprehensive family assessment that is developed in conjunction with the family. The greater changes are expected to occur through re-training, supervision and the measurement of skill development. Line staff in all divisions will receive training on how to engage families in the process of assessment, interviewing techniques and tools, and documentation of the assessment leading to enhanced decision making. Supervisors in all divisions will receive training and support on how to effectively supervise and measure the development of skills in their staff to ensure case reviews and decision making are driven by the enhanced, comprehensive and documented family assessment. This format and the associated training and supervision outline will be included in our Program Improvement Plan. Current practice and planned practice enhancements are dependent on workload demands and a concurrent plan for mapping the expectations of line staff and supervisors to ensure that their time and activities are spent toward the achievement of safety, permanency and well-being outcomes.

In May 2003, the Administrative Review Unit began inviting parents/guardians, foster parents and youngsters 16 years and older to the administrative review. The scheduler for the ARU checks off those invited on the invitation section and the review officer checks off those who attended the review. Our MIS is able to collect the data through RICHIST to determine attendance rates; however, our system is not yet able to produce a report on attendance rates. This request is one of many on the list for MIS staff.

Even earlier, in March 2002, the Department initiated a process for Family Team Meeting (FTMs) as part of the work design for the Administrative Review Unit. This is a voluntary program in which the Family Service Unit social workers can offer the meeting either for families or individuals, though the parents are not obligated to participate. A family team meeting provides a structured time for the family, community and the Department to have

facilitated discussion regarding a family's strengths and concerns. Some of the goals of the family team meeting include the development of a mutually agreed upon case plan and the identification of available kinship supports and potential placements.

This process is designed to encourage and empower families to become involved in decision making and planning to protect their children from further abuse and neglect. Family team meetings bring together family, including extended family and other community and professional supports to make decisions in partnership with the Department regarding the safety, permanency and well-being of their children. Administrative review officers, located in the four regions of the Department, serve as facilitators for the meetings which occur in all regions. There is a family service coordinator who is responsible to contact families and other participants to make necessary arrangements for the family team meetings. Family Service Unit caseworkers assigned to the case are expected to refer families for family team meetings as well as to attend and participate in the family team meetings.

As of September 30, 2003, fifty-five (55) families were referred to the Administrative Review Unit for a family team meeting. Of that number, twenty-four (24) family team meetings were held. Families were asked to complete a voluntary evaluation after the family team meeting. The number of responses has not been significant but those who did respond as well as verbal feedback from other participants does represent that families have felt respected and part of a team that is making decisions about their children's lives. FSU caseworkers and supervisors who have completed six month evaluations report that the family team meeting was helpful to connect family members, to foster a positive relationship between the family and the Department, to assist the parents to recognize existing supports and to help the family develop a crisis plan that was useful in avoiding placement

At a youth focus group held in August 2003, ten (10) out of thirty-six (36) youth who participated indicated that they had contributed to the development of their case plan. This focus group developed several recommendations to the Department which are discussed in more detail in "Section E, Question 3" of this document.

> 3. Citing any data available to the State, discuss how effectively the State is meeting the requirement that the status of each child in foster care be reviewed periodically, i.e., at least every 6 months, by a court or by administrative review.

The Administrative Review Unit (ARU) within the Department is charged with the responsibility to complete periodic reviews for children in foster care every six months. Review officers are assigned to each of the four regional offices and case plan reviews take place in the regional offices. In our 2000 pilot CFSR an area needing improvement was notification to youth and foster parents of upcoming Administrative Reviews. In response to our voluntary Program Improvement Plan (PIP) we have developed a system whereby ARU staff notify parents, legal guardians, foster parents and youth 16 and older of any upcoming review and encourage their participation. As indicated earlier, this past May, ARU began to send out invitations to the birth parents, foster parents and any child over the age of 16 using information available in RICHIST

to complete this task. Administrative Review Unit staff report that they have seen a noticeable rise in attendance of biological, foster parents and youth as a result of this change.

Importantly, too, the case reviews are all happening in a timely manner within the six (6) month review period. Family Service caseworkers receive an automated message via e-mail notifying them of the need to schedule a case plan review approximately six weeks prior to the time frame within which the review needs to be scheduled. Once the caseworker chooses a date for the review, the scheduler, within the Administrative Review Unit, sends the invitations and monitors the process. Caseworkers are expected to assist parents and children with transportation to the reviews, if necessary. Notification to other valuable participants, such as service providers, is a responsibility shared with FSU workers. Historically, recommendations that are provided by the review officer at the end of the review are not used or tracked by the Department to determine outcomes over the six (6) months following the review. The Department plans on the Administrative Review Unit taking on a quality assurance role in the near future, however. Our MIS system will be able to collect data from a newly designed form and measure outcomes from the recommendations.

As already referenced, the Administrative Review Unit has developed a review form that addresses safety, child and family well-being, visitation, child's needs and services, involvement of family members in case planning and permanency issues based on ASFA-related language. At the present time, this information is maintained on an individual child and family basis only; but, the Department is planning to develop a form that will allow the collection of aggregate data on these issues. This information will be used for quality assurance purposes.

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4. Citing any data available to the State, discuss how the State meets the requirement that permanency hearings for children in foster care occur within prescribed timeframes. Discuss the effectiveness of these hearings in promoting the timely and appropriate achievement of permanency goals for children.

The Department and Family Court have made substantial progress in collaboration on issues of mutual interest and in particular on ensuring that permanency hearings are held and are effective. Family Court judges use a new and separate form for permanency hearings that ask a different set of questions and are documented differently on the decree. Workers submit their case plans which document their permanency plan and after appropriate discussion those case plans are approved with or without needed changes.

The Department also uses a permanency hearing court disposition form that was developed in collaboration with the Family Court. Upon completion of a successful permanency hearing, information is captured on a newly developed Permanency Hearing Decree form. The Department did not previously have the capacity to track permanency hearings in RICHIST. Since our Pilot CFSR in 2000, the Department has developed and is in the process of implementing a program to track Permanency Planning Hearings (PPH) for children in substitute care. A PPH module was programmed into RICHIST in order to accomplish this. The

department has assigned a legal technician to work on collecting current and historical data and entering it into the PPH module.

Several reports (listed below) are generated in order to identify children who need to have a PPH scheduled:

- Children who have been in placements for 60 days or more
  who do not have a PPH scheduled in RICHIST
- Children in placement via a Voluntary Placement Agreement
  who do not have a PPH scheduled within 180 days of placement
- Children whose parents' parental rights have been terminated
  and do not have a PPH scheduled within 30 days of the TPR
- Children who a PPH but the hearing did not meet federal guidelines
  regarding reasonable efforts
- Children who have been in placement for 365 days or more
  and children whose last PPH was held in excess of 365 days

The legal technician reviews the reports and researches the cases to determine if a PPH occurred. If a PPH did not occur, a request to schedule a PPH is sent to the Legal Office. A motion is then presented to the Family Court and a PPH is scheduled. If the legal technician discovers that a PPH occurred, the decree is reviewed for federal language and the RICHIST PPH module is updated with the current information.

On a daily basis, the legal technician gathers new decrees and PPH scheduling forms from the Legal Office and enters that information into the PPH module. A report will also be sent to caseworkers and casework supervisors that will identify children who have a PPH scheduled within the next 60 days.

With few exceptions, the permanency hearing meets all of the federal requirements. The new forms and decrees ensure the appropriate questions are being asked and answered followed by an appropriate discussion regarding permanency, thereby increasing the effectiveness of the hearings. Also with few exceptions, the Family Court judges move forward on a termination of parental rights petition even if the child is not already placed in a pre-adoptive home. The usual participants, Department social work and legal staff, CASA staff, Public/Private Defenders, providers, Parent(s) attend the permanency hearings and Department staff, where necessary and appropriate, provide transportation for families. The process and forms ensure a basic level of consistency occurs at hearings but the quality of the hearing remains tied to the practice and philosophy of the individual judge and Departmental staff.

5. Citing any data available to the State, discuss how the State meets the requirement to provide foster parents, pre-adoptive parents, and relative caregivers of children in foster care with notice of and an opportunity to be heard in any review or hearing held with respect to the child in their care.

In accordance with Department policy, primary service workers are responsible to notify foster parents, pre-adoptive parents and relative caretakers of any court proceedings regarding children in their care. The primary service worker is responsible to send out a Notice of Court Proceedings (DCYF #083), if possible, to the respective caretaker no later than two (2) weeks prior to the date of the scheduled proceedings. This notification template is available on the computer and can easily be completed by workers and/or clerical staff. When it is not possible to provide written notification due to the scheduling of a court hearing without much advance notice, the worker notifies the caretaker verbally once the worker is informed of a court date. Under Rhode Island General Law 14-1-30-2, foster parents/relative caretakers and pre-adoptive parents have the right to file a written or verbal report with the Court to convey information relevant to the child in their care, but they are not considered a party to the proceedings in Family Court and cannot present testimony through the presentation of witnesses or cross-examine any witnesses.

Generally, caregivers do not regularly attend court hearings. This is an issue that was discussed at the annual Foster Parent Town Meeting held in May 2003 where foster parents and Department staff reviewed some of the obstacles to foster parent participation in court hearings. Foster parents requested that the Department provide training to foster parents on relevant aspects of the legal process as it relates to their foster children and status as care providers. In particular, foster parents requested that training should focus on the rights of foster parents to be heard by judges and others in the legal processes relating to their foster children. It was suggested that members of the legal community, including DCYF attorneys, Family Court judges, and CASA attorneys be included in the training. The Child Welfare Training Institute has agreed to work with the Rhode Island Foster Parents' Association (RIFPA) to organize and implement this type of training.

As mentioned earlier, foster parents, pre-adoptive parents, and relative caregivers are given the opportunity to participate in the administrative review process. Beginning in May 2003, the Administrative Review Unit began sending out the invitation notices four weeks prior to the scheduled date of the case plan review to parents, foster parents and youth over the age of sixteen (16). Previously, this was the responsibility of the primary service worker. This is expected to increase attendance and the effectiveness of the review. Anecdotal information to date from the Administrative Review Unit suggests that there has been increased attendance by foster and biological parents since change was implemented.

C. Quality Assurance System

> 1. Discuss how the State has complied with the requirement at section 471 (a)(22) of the Social Security Act to develop and implement standards to ensure that children in foster care placements are provided quality services that protect their health and safety, and any effects of implementing the standards to date.

The Department has regulations that govern foster care, day care, child placing agencies and child care agencies. The Licensing Division is currently in the process of updating:

- Regulations for Day Care Homes

- Regulations for Child Caring Facilities (e.g., Group Homes)

- Regulations for Foster Care

- Adoption Policy

- Criminal Disqualifier Policy

New child care regulations are close to being promulgated. Regulations governing crisis intervention and restraint are now in effect, and will be cross-referenced with these new child care regulations. Additionally, a recently revised policy regarding Removal of a Foster Child has just been adopted in the Department. Licensing staff closely monitor group care facilities, as do program monitors for contracted placements through the Division of Children's Behavioral Health.

Historically, adoptive homes have not been licensed, only approved. The Department is now moving toward licensing of DCYF adoptive homes which will require a fire inspection. At this point, however, these licensing requirements will only affect adoptive homes that are recruited for DCYF involved children. The Department is considering whether to revise its criminal background standards to more closely conform to federal requirements regarding consideration of applicants who had a prior involvement with a criminal offense(s) that were disposed of with no subsequent offenses for five years or more.

For foster and adoptive homes, worker feedback and reviews by licensing staff are the primary means of quality assurance at present. The licensing standards are the same for relative and non-relatives whether or not the families are receiving foster board payment from a private agency. The Department offers a shorter more intensive training for kinship providers who are unable to attend the regular nine week training, though they are encouraged to participate in the longer training if they can. State law was recently been changed to permit licenses to be renewed every two years instead of annually. This change was considered as part of the Department's interest and need to expand its foster care capacity through ongoing recruitment, facilitating licensing procedures to be accomplished as timely and expeditiously as possible for the newly recruited homes, as well as to allow licensing social workers an opportunity to interface with foster parents more frequently.

2. Discuss the effectiveness of the agency's quality assurance system in helping to ensure safety, permanency, and well-being for children served by the agency and their families in all jurisdictions of the State. In responding, discuss the jurisdictions in the State covered by the quality assurance procedures, the capacity of the system to evaluate the adequacy and quality of the State's child and family services system, and its capacity to produce information leading to program improvements.

At this time the Department does not have an identifiable Quality Assurance (QA) function that meets the requirements of the CFSR. There are a number of activities and initiatives that have begun and are evolving toward a mechanism for quality assurance. At the present time these functions are not integrated, though efforts are underway to promote better coordination. It is clear that this gap in our ability to self-evaluate is of great importance to us as well as a mandate for our Program Improvement Plan.

This past year, the Department worked with the Governor's Office and the Budget Office to allow an internal transfer of personnel which allowed DCYF to begin working on establishing a quality assurance function within the Department. This important function was created, though there is currently a hiring freeze across all departments. Elaine Squadrito was transferred from her position as Regional Director to work full time on preparation for the Child and Family Services Review scheduled for March 2004, the resulting PIP and the development of a Quality Assurance function.

The Department has also moved to create an Integrated Planning and Evaluation Team comprised of representatives across DCYF, with planning responsibilities for Child Welfare, Children's Behavioral Health, and Juvenile Corrections, and involving representatives from financial management and MIS. This team will focus on linking internal initiatives through better communication and support. Additionally, this team will assist in strengthening the strategies and approach for making the Child and Family Service Plan a more comprehensive plan for all of the Department's divisions.

Members of the Integrated Planning and Evaluation Team have begun meeting to map the various QA/QI functions and lead responsibilities. By March this subcommittee will have a draft to share with the entire Team and will then forward with edits to the Senior Executive Team for approval. The activities that will ensure an identified QA/QI function is put into place will be a vital part of the PIP.

In the past year other organizational changes have been made to assist in the development and implementation of quality assurance throughout the agency. The Administrative Review Unit (ARU) has come under the auspices of the Child Welfare Training Institute, which has primary responsibility for training and implementing the family-centered practice initiative. Further, the Department has consolidated the operations of foster/adoptive parent recruitment, training, and licensing under the supervision of the Associate Director of Child Welfare. This change

provides greater continuity and support, as well as increasing training capacity for foster and adoptive parents.

The Division of Children's Behavioral Health and Education within the Department has a range of responsibilities including monitoring contracts and activities relating to residential placement for children and youth in care. Program monitors serve as liaisons between Department staff and the provider agencies and trouble shoot issues involving children's behavioral health or other residential service needs. They maintain ongoing contact with the provider agencies and have the responsibility for making site visits to the shelters, group homes, and residential treatment placements. They examine the records of youth in the various placements to ensure that their case plans are being followed and that appropriate services and treatment measures are in place. Additionally, a hospital liaison works with the two psychiatric hospitals providing a utilization review of children and youth requiring an acute level of care.

All of the children and youth in substitute care are now enrolled in the state's managed care health plan operated by Neighborhood Health Plan of Rhode Island (NHPRI) and Beacon Behavioral Healthcare Strategies. This health and behavioral health care coverage provides care management and coordination for the children and youth in DCYF custody. The Beacon Behavioral Healthcare coordinators also work closely with DCYF's hospital liaison and the psychiatric hospitals to ensure appropriate levels of care and treatment.

The Department is continuing its contract with an outside agency, Placement Solutions, to provide a Utilization Review function. Placement Solutions has established improved communication and understanding of the placement needs of children who have been placed in programs located in-state and out-of-state. Staff from Placement Solutions visit the programs to review case records and assessments on treatment progress, helping the Department to plan for the transition and treatment needs of youth moving from intensive treatment settings to less restrictive, community-based treatment programs.

Working with our Care Management Teams and DCYF's internal Resource Management Team, the utilization review effort identifies the services necessary to make effective transitions, and this has resulted in the steady shift from out-of-state and nearby residential placements to in-state residential treatment, therapeutic foster care, and back home with necessary wraparound supports. The combined efforts of Placement Solutions and Department staff has resulted in a 53% decrease in the number of youth located in distant out-of-state treatment facilities. Between July 2001 and September 2003, there was a reduction from 70 distant residential placements to 33. There was also a reduction in Massachusetts residential care in that same period from 126 to 66 or 48%, an increase in Rhode Island residential care from 104 to 115 for an 11% increase and from 46 to 96 specialized foster care placements for a 109% increase. Additionally, the data being collected by Placement Solutions is being incorporated into our RICHIST system in order to provide regional staff with up-to-date information on the status of youth in residential placement. The Department is in the process of developing regional data sets so that Regional staff can measure their performance and set goals for improvement on all active caseloads. Our performance measures will, at least initially, mirror the performance measures of the CFSR. In the future we do anticipate that there will be an opportunity to add to the initial required measures, to possibly include staff driven performance measures.

Rhode Island is fortunate to be one of a handful of states in the nation that has a SACWIS system as sophisticated and capable as is the RICHIST data system for the Department of Children, Youth and Families. As referenced earlier, the Department received a grant from the U.S. Administration for Children and Families to develop a Child Welfare Data Analytic Center. We are working with the Consultation Center at Yale University to establish this capability and are now in the third year of this grant funding. Yale University has made great strides in developing the foundation for the DCYF's ongoing capability for data analysis. As a result of these two interlinking activities, the DCYF can now focus more clearly and effectively on the data trends and analysis of the underlying factors contributing to changes in performance. Being able to see and understand Rhode Island's experience compared to other states is important for our own quality assurances, but more important for DCYF to observe our own changes in performance over time and understand the factors contributing to these changes.

A number of evaluation and outcome focused initiatives are at the forefront of Yale's work with the Department, including:
- reporting on performance measures for all of the contracted programs,
- assisting with the evaluation of our community-based Children's Intensive Service program which is an outpatient mental health service for serious emotionally disturbed children;
- creating a longitudinal study and analysis on the Department's child welfare data that is also used for the AFCARS reports; and
- working with the Department in preparation for the CFSR in March 2004.

The Yale Consultation Center is also providing focused/intensive program evaluation for Project Hope, which is a five year research initiative begun in 1998, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to provide wraparound case management and support services to youth leaving the Rhode Island Training School.

As DCYF moves closer to developing a planning and evaluation capacity, the data and outcome measures will become an underlying basis for driving critical decisions in developing services and the delivery capacity for more effectively meeting the needs of children and families in our care.

The CFSR process has afforded us not only the mandate but the opportunity to develop an integrated, internal and ongoing quality improvement process which will address the performance measures required and establish a climate where discussion and measurement of quality is part of our everyday life. Supervisors will play a key leadership role in the development and implementation of our QA initiative. Managers are supportive of the need for such a function and are ready, willing and able to engage in the process of improvement.

The DCYF Director has also begun to focus more attention on ways to integrate the various components of a quality assurance mechanism to ensure that a system can be established internally that will provide critical reports on outcomes, practice and compliance measures. The staff involved in the discussions regarding the development of an integrated, ongoing QA function include the CFSR Coordinator, CWTI Director, ARU Supervisor, Policy Director, Yale University Consultation Center, and the Planning and Evaluation Integration Team.

D.   Staff and Provider Training

1. Citing any data available to the State on the numbers and timeframes of staff trained, discuss the effectiveness of the State's initial and ongoing training for all child welfare staff employed by the agency that includes the basic skills and knowledge required for their positions.

The Child Welfare Training Institute, created in June 2001, is a collaboration between DCYF and the Rhode Island College of Social Work. It provides a six (6) month pre-service training for new Social Caseworkers and a one month training course for Child Protective Services investigators (CPS). The pre-service training curricula for both Social Caseworkers and Child Protective Investigators were developed through the collaborative efforts of the Child Welfare Training Institute, DCYF Family Service Units and CPS, staff from the Rhode Island College School of Social Work, and representatives of community service providers.

The six (6) month course is offered three times in the year. In each of these six month courses, participants are given 224 hours of in-class training, and 354 hours of in-field work. Each topic requires between 3 and 18 total hours of class time, with the exception of Spanish instruction which is 45 hours. The training combines classroom work with actual case practice, thereby allowing a transfer of learning to occur through experiential activity. The new hires are assigned to family service units with a supervisor. Their six month probation period runs concurrently with the pre-service training activity, so it is assured that they will complete their training requirements. The Training Coordinator provides regular progress reports to the Family Service Unit Supervisor which helps to inform the probationary reports at 2, 4 and 6 month intervals. These reports determine whether the supervisor will recommend that a new employee passes probation.

The classroom work covers a range of topics designed to enhance knowledge, skills and abilities that are identified for this particular job. Classes on best casework practice include 12 hours of interviewing skills. Classes in professional growth and development are designed to support the career goals of the new worker in addition to facilitate working effectively and cooperatively as part of a team. There are several classes on personal safety, and safety of transporting infants and children which includes a car seat safety program taught by the trainers from the Governor's Highway Commission. A six hour worker safety program is taught by staff that is annually certified by the Crisis Prevention Institute in Wisconsin. More than 60 hours of training, including 12 hours on child sexual abuse, are provided under the general category relating to

child abuse and neglect. Nearly 30 hours of computer training are taught, most of it related to necessary casework functions in RICHIST.

The first six weeks of this pre-service training for Social Caseworkers are spent in the classroom. In the second month, each new worker begins spending one day a week in the field. The experiential learning process gradually increases. By the sixth month, workers are spending just one day a week in the classroom. The rest of the week is spent working with families. At this point, new workers will have a caseload of 10 to 12 families. This graduated caseload arrangement allows the caseworker to apply information learned in the classroom and on site visits to relevant service providers and programs to actual cases. The Family Service Unit Supervisor is responsible for handling caseload emergencies, or demands, for cases assigned to the new social caseworkers during their pre-service training period. The training program is the agreed upon priority for new staff. Since the creation of the Child Welfare Training Institute, three pre-service programs have been held for a total of 40 Social Caseworkers. Thirty-two stayed with the Department, and eight others either resigned, did not pass probation, or left for other reasons during the first six months.

Pre-service training for Child Protective Investigators emphasizes knowledge in risk and safety assessment, forensics, medical information, investigatory practices, roles of the police, and recording case information into the state's information management system, RICHIST. Most of the new investigators are seasoned DCYF staff that are changing divisions within the Department and therefore already possess knowledge, skills and abilities relevant to the job.

The Training Institute also uses a comprehensive list of skills and knowledge for the CPS staff, which is integrated into each class curriculum, as with the pre-service curricula for the Social Caseworker. These were created by a team of CPS supervisors with the assistance of a professor from the School of Social Work at Rhode Island College. These were used to guide the expansion of the pre-service for CPS investigators from a 2 week model to the one month model we currently use. In 2002, the Institute held one CPS pre-service for 5 new investigators.

Evaluation Methods
In both pre-service courses for the Social Caseworker and the Child Protective Services Investigator, each participant evaluates the relevancy of the material to the job and the effectiveness of the instructor at the conclusion of each class. The instructor, in turn, evaluates each student on level of participation and ability to relate the class material to their job.

Grades are given for quizzes and for the final exam and are included in progress reports generated by the two pre-service co-coordinators at the Child Welfare Training Institute. Progress reports are written for each student at the 2, 4, and 6 month time frames, which are intended to synchronize with the probationary reports generated by each student's supervisor. The progress reports are attached to each probationary report and filed with Human Resources as part of each student's permanent record. Routine reports are provided to the advisory board of all activities of the Institute.

The CWTI has also formed the Family Services Pre-service Committee which provides feedback, offers expertise, and reviews the evaluation instruments and resulting data. This committee is comprised of staff and in-house trainers, staff from other DCYF divisions such as child protective services, the foster care and adoption unit, and juvenile probation in addition to

community trainers and one faculty member from the School of Social Work at Rhode Island College.

In-Service Training
The Department also requires that experienced social work staff attend a minimum of 20 hours of training per year, and the CWTI provides a full curriculum to meet this in-service requirement. CWTI has also held several programs after the typical work hours of 8:30 - 4:00 which has been necessary in order to accommodate some work shifts within the department. This has been well received and has also proved to be helpful to staff who wish to take certain classes and need to plan in advance. Training activity for staff is ongoing, however, tracking each staff person's training record for compliance in RICHIST continues to be an area in need of improvement.

In the progress report for the period from July 1, 2002- June 30, 2003, the Director of the Child Welfare Training Institute stated that there were 65 training sessions held for DCYF staff overall. A total of 1,105 participants attended. A wide array of topic areas was represented, including issues relating to:
- visitation
- substance abuse
- domestic violence
- case plans, and
- interviewing

In addition, Spanish for social caseworkers and clerical, advanced family assessment, child development, prison visitation, psychiatric evaluations, sexual abuse, medical issues in abuse and neglect, interviewing and interrogation techniques for CPS investigators, numerous computer classes in RICHIST and with other programs; and, emotional intelligence for supervisors were also offered at least once over the last year.

The following list of in-service training topic areas is an example of the training program designed to promote staff competence in areas of safety, permanency and well being.

1. *Adolescent Training* - 3 separate programs to teach participants a developmentally based model for independent living, to teach assessment tools to measure an adolescent's level of skill and competency, and to use a team approach to providing independent living services.

2. *Advanced Case Plan Training* - 1 day training - review of effective case planning and instruction on integrating family centered practice principles and developing strength-based case plans. The program includes actively involving the parents and children (age–appropriate) both in the case planning activities and for input in the development of the actual case plan.

3. *Child Development from Infancy to Adolescence: Normative development as a paradigm for understanding and intervening in abuse and neglect* - 3 day workshop - provides an overview of normative development in infancy, childhood and adolescence as a guide in the assessment and case planning for families in which abuse and neglect has occurred.

4. *Computer Training* - With each new release of RICHIST, hands-on and/or on-site demonstrations are offered on the changes and how to navigate them to staff that are responsible for the respective data affected by those changes.

5. *Cultural Competence* - The department recognizes that improved diversity efforts must be made and defines diversity as multi-dimensional. Towards that end the Child Welfare Training Institute offers the following training:

   ➢ Spanish Language & Culture for Child Protective Services, Family Services, and Clerical: 3 training programs teach basic Spanish, as well as emphasizing the unique knowledge and skills required by each division/classification.

   ➢ Working with Latino and Portuguese - 1 day program - designed to provide knowledge to any line staff that work directly with families regarding the trauma of migration, values within families, and systemic factors such as isolation, discrimination, and encounters with bureaucracies.

   ➢ Gay, Lesbian and Transgender Issues - 1 day program - addresses the process of coming out for adolescents, the special needs of this population who are in the DCYF system such as placement issues, and the discrimination and oppression that lead to an increase in substance abuse, physical and sexual abuse, suicide, homelessness and depression in this population.

6. *Educational Services* - The department's efforts to improve the educational well-being of children are met in this six-hour training that has been updated from an earlier training to include more intensive advocacy for services for children.

7. *Family-Centered Practice Initiatives* - Numerous agencies including Family Service, Children's Friend and Service, Child and Family Service of Newport County, and the Providence Children's Museum have been involved in this initiative through collaboration with the department. It is expected that this strength-based approach to working with families will impact positively upon the safety, permanency and well-being of children, for example, by:
   o reducing the number of out-of home placements,
   o improving services to families whose children are at home, and
   o through efforts made to engage the parents, extended family members, and the community.

8. *Neighborhood Health Plan* - Regional training instructs line staff and foster parents on access and availability of health care for children and their families. Topics include RIte Care eligibility and benefits for children and adolescents in foster care and in the home, and behavioral health initiatives such as ADHD screening.

9. *Quality Improvement Training Programs for Supervisors, Administrators, Managers* - *Se*veral new initiatives address the training needs of this group within the department:
   ➢ Quality Assurance for new investigatory model for supervisors and administrators of the division of child protective services
   ➢ Emotional Intelligence for Supervisors and Managers

➢ Fact-based decision making for supervisors and managers for all divisions
➢ The Office of Training & Development at the Department of Administration offers an 18 hour core course for all state department supervisors and managers titled *Principles of Management*. This is part of an effort at OTD to establish a formal Management Development Institute.

10. *Sexual Abuse* – training addresses characteristics and needs of victims and offenders, interview techniques, and family and treatment issues.

11. *Substance Abuse -*
➢ Alcohol and Substance Abuse Educational Series
➢ Adolescent Relapse Prevention

12. *Support Staff Training -* 7 training programs - include developing communication skills, computer training to improve communication, time management and team work, and developing problem-solving skills in the workplace.

13. *Visitation Training* - 18 hour class - addresses the relationship between visitation practice and reunification, as well as separation and loss for the child in placement, and the importance of preserving connections for children who are in placement with their birth families, significant relatives or others in their lives, as well as with their communities.

The in-service training programs are also made available to community providers on a regular basis. Those programs that are designed for specific DCYF staff classifications, however, are opened first to the Department for registration, and non-DCYF registration is then offered if space allows.

Cross-training opportunities are offered among DCYF's different divisions, as well as with service providers. One example is the training on interviewing techniques for DCYF's child protective investigators, in which the registration included Juvenile Detectives from several local police departments, medical personnel from the Hasbro Hospital Child Protection Clinic, and staff from CASA. The Department's training on Family Centered Practice is another example in which participation included representatives from Family Court, Community Mental Health Centers, residential programs and other community service providers.

The Department also offers a continuing education program for qualified employees to pursue a Master's Degree either on a part-time or full-time basis in social work or other related fields. There is one full-time and four part-time educational leave opportunities granted.

Continued Quality Improvement
Training topics have expanded to offer a variety of innovative programs, such as the role of the biological father in a family, and prison visitation. One interesting development has been in the area of merging several overlapping child welfare topics, thereby taking a systemic approach to working with families. One example is the inter-relationship between substance abuse and domestic violence. Both of these training events incorporate areas of the other issue and relate them to case work challenges.

The CWTI continues to apply for incentive credit programs through the Office of Training at the Department of Administration, and has expanded these 3 day programs to include computer training classes. Continuing education credits are also pursued through the School of Social Work at Rhode Island College. Certificate programs are a recent development for DCYF staff to work towards, such as the child protective services certificate program in investigation skills and a certificate program for support staff.

Areas in Need of Improvement

- It was noted that increase in caseloads leads to a decrease in training and numerous last minute cancellations. It was noted many trainings fill up fast. It was suggested department Supervisors assess the educational needs of workers and determine which trainings workers need to attend and then take steps to ensure worker is able to participate in the training. This would have to be with agreement of worker, as supervisor has no jurisdiction to make a worker participate in training.

- CWTI representative advised calendar of proposed training offerings are provided to administrators 6 months in advance. It was suggested Supervisors receive this calendar.

- There is currently no training curriculum for newly promoted supervisors, and there is no in-service training standard for supervisors.

- Lack of employee evaluation process noted to be a significant issue for Department. It was suggested Department explore an evaluation process for employee file – even if there is no monetary connection.

- Need opportunities for vendors and other community-based agencies to receive training as part of contract requirements for vendors to demonstrate cultural competence (race, gender, sexual orientation, gender identity, religion/spirituality, etc.). Strongly consider creating a listing or menu of available or required training such as that offered by the Rhode Island Council of Resource Providers for Children, Youth and Families (RICORP), Department of Administration (DOA), Drug and Alcohol Treatment Association (DATA), etc.

- Need mechanism to regularly assess training needs through CWTI and/or supervisors: ways to utilize information about types/kinds of training being attended in order to plan for staff development opportunities.

- Need to explore the desirability and interest in regional, on-site trainings versus those centralized at CWTI.

2. Citing any data available to the State, discuss the effectiveness of the State's training of current and prospective foster and adoptive families and the staff of State-licensed

> or -approved child care institutions that care for children in the State's care or responsibility that addresses the skills and knowledge base needed to carry out their duties.

The Governor's Commission to <u>Study the Placement of Children in Foster and Adoptive Care</u> in 1999 called for the Department to *"restructure the manner in which foster and adoptive parents are recruited and trained,"* pointing out the need to focus more attention on concurrent planning. Responding to these needs, the Department has increased its capacity to train, assess and approve foster and adoptive parents. Two Clinical Training Specialist positions have been added to the Adoption and Foster Care Preparation and Support Unit increasing the total to five Clinical Training Specialists under the supervision of a Chief Casework Supervisor.

Today, approximately 80% of adoptions within DCYF are foster parent adoptions. Additionally, many adoptive families are willing to take legal risk placements. (A legal risk placement represents that the parental rights of a child have not been terminated, but the Department has begun proceedings in Family Court.) With these trends in mind, the Department initiated dual training of foster and adoptive parents in January, 2002. Foster and adoptive families now receive the same training, which emphasizes a concurrent model of foster care and places extra emphasis on cultural competency issues.

Training sessions are held in several locations throughout the state, including Providence, North Kingstown and Woonsocket. Most classes are held in the evenings and some Saturdays, only occasionally are these training sessions scheduled during the day because there are not enough applicants to conduct a class. There are approximately 25 different training groups held during a year.

The Department's pre-service training is built on a core curriculum that is designed to prepare families for parenting a child in the child welfare system with special needs. Applicants must successfully complete the 27 hours of training in order to be approved and/or licensed. The curriculum for the training sessions focuses upon information sharing and skill building and covers a wide range of topics. Resource family assessment and pre-service training includes the following topics:

- An Introduction to the Continuum of Care
- Family Systems, Race, Culture and Diversity
- The Experience of Childhood Abuse/Neglect & Issues of Discipline by Care Givers
- The Experience of Childhood Abuse/Neglect & Issues of Discipline by Care Givers
- The Experience of Childhood Sexual Abuse and Its Impact
- Child Protective Investigations & the Placement of Children
- The Experience of Childhood Separation and Loss, Its Impact & Children's Need to Hold onto Memories
- The Impact of Trauma on Child Development and on the Child's Capacity to Form Trusting Attachments
- Working with the Department and with Birth Families toward Achieving Permanency for children.
- A Panel Discussion with resource families
- Resource Information & Saying "Goodbye"

In addition, the agency has begun to offer separate kinship classes for relatives unable to attend the full ten week training sessions. This training is offered at least once every two months. It is a six hour course which is offered either as one 6 hour day (Saturday) or two evenings (3 hours each night). The curriculum covers all of the core issues such as child development, how to interact with the Department, and how to deal with a child who has been a victim of sexual abuse from the kinship perspective.

From September 2002 to August 2003, 324 foster families were invited to training. 192 families completed the training. 67 adoptive families were invited and 44 families completed the training. At the present time, there is no ongoing training requirement for foster parents. There are ongoing discussions with the Rhode Island Foster Parents Association (RIFPA) to create a process to evaluate the effectiveness of the training and ongoing training needs of foster and adoptive families.

Recommendations from the Foster Parents' Town Meeting this past May relate to the need for stronger support and in-service training for foster homes, which relates to reducing multiple placements. Some areas that foster parents have requested more training on include:
- the child protective investigative process,
- how to address challenging behavioral issues presented by children in their care,
- the legal process, and
- the resource family's role in that process and sexual abuse issues

Additionally, concerns have been raised that relative/kinship providers experience a significant delay in being reached for training. It has also been recommended that the Department look at options beyond our system to provide greater opportunities for training in available community-based settings such as specialized foster care agencies – RIFPA – CWTI at RIC – Independent Living Programs, etc. Following up on the recommendations, the Rhode Island Foster Parents Association (RIFPA) would like to develop a concise listing of trainings taking place across the state and make it available to foster parents in their newsletter and on their web site.

Some states offer general training for foster parents when they start and then require ongoing training specific to issues of children they are caring for. It was noted foster parents may need encouragement to participate. The RIFPA Mentor program is beneficial in providing support to foster parents. RIFPA received a grant for regional support and education for the mentoring initiative.

The Department recognizes that there is value in maintaining a standard for in-service training for foster parents and is currently developing an in-service training model. Foster Parents will be asked to complete a certain number of training hours (yet to be determined) during the two year extent of the licensing. Training will be offered in a variety of venues and sponsored by a variety of agencies such as DCYF, Child and Family Services of Newport, Casey Family Services, Children's Friend and Service, Sexual Abuse and Trauma, Adoption Rhode Island, Family Service, Inc. and RIFPA. In some cases the training event will be open to the community at large. Foster parents will be provided with a listing of scheduled training opportunities and will receive updated training announcements with their foster board checks and/or in the RIFPA newsletter. In order to encourage attendance at training, an incentive of some type (yet to be determined) will be offered to those who participate.

New and on going trainings are strongly encouraged for all Court personnel (including Judges), foster parents (including seasoned caregivers), and workers to keep everyone abreast of new Departmental initiatives (such as Family Centered Practice, concurrent planning, etc).

Still, it is recognized that new methods of communication regarding such initiatives must be employed and better coordinated through available means, such as newsletters, mailings and trainings.

E.   Service Array and Resource Development

> 1.   Discuss how effective the State has been in meeting the title IV-B State plan requirement to provide services designed to help children safely and appropriately return to families from which they have been removed.

Services Available

The Department accesses a full array of assessments and services for families and children entering DCYF care, in order to determine the strengths and needs of the families in planning the reunification and permanency goals. The array of services includes:

- Sexual abuse evaluations and treatment
- Sex Offender Treatment Program at the Rhode Island Training School (RITS)
- Straight Ahead (residential substance abuse program for 24 male residents of the RITS)
- Substance abuse evaluation and counseling for youth and adult caretakers
- Sober Parenting (parent education classes for DCYF adult caretakers enrolled in outpatient substance abuse counseling at any Codac site.)
- Methadone Reunification Program – funding which allows DCYF clients who have lost insurance coverage due to children being removed from the home to continue to participate in a methadone maintenance program.
- Mental health evaluations and counseling
- Anger management/domestic violence
- Interpreter services
- Vulnerable Infants Project
- Section 8 Family Reunification Certificates and other housing assistance
- Parent education services
- Parent aide services
- Transportation
  (RIte Care recipients are eligible for bus passes that can be used for transportation to medical appointments as well as for general usage. The health plan also provides taxi services to medical appointments when the member meets the criteria established by the health plan)
- RI Foundation Parenting Program through Providence Center geared toward children under the age of five.

- Child and Adolescent Service System Program (CASSP) for wraparound, non-traditional support for children with special needs
- Children's Intensive Services (CIS) for children with serious emotional disturbance

Additionally, the Department is working with Children's Friend and Service, a multiple social service agency which has just completed a federal demonstration grant through the U.S. Department of Health and Human Services, Administration for Children and Families for a concurrent planning service model. Staff from this demonstration project, Partners in Permanency, actively participated in the family centered practice initiative at the Department. In their semi-annual report from October 1, 2002 through April 30, 2003, the Partners in Permanency Program reported that since its inception, the program has provided permanency for eighteen (18) children. Six (6) have been reunited with their biological parent, nine (9) have been adopted and three (3) have entered into a legal guardianship arrangement. All of the children who were adopted had some degree of openness with their biological families except for one (1). The success of this program is directly related to the quality of collaboration and partnership that DCYF social workers, supervisors, legal staff, families and other provider agencies feel toward the Partners in Permanency staff and the strength-based program design, as well as collaboration with the Family Court.

This program began as a federal demonstration grant project, and is widely respected by the social work staff throughout the Department. During the demonstration phase, the program was under intensive evaluation collecting a wealth of information on the participating children, birth parents and foster parents or kinship providers, and information regarding permanency timeframes for the general DCYF population. This information was used for case planning purposes, and also to determine the project's effectiveness in meeting its goals. The participation of DCYF social workers, supervisors, administrators and legal staff on the Partners in Permanency Coordinating Committee also enhanced collaboration activities and contributed significantly to improved permanency outcomes for several children participating in the program. The IV-B Planning Committee committed funding support for the continuation of this program when the demonstration project ended in early 2004.

Project Connect is another program of Children's Friend and Service which began as a demonstration project. The program is designed to provide comprehensive wraparound support for DCYF-involved families affected by substance abuse. Project Connect has demonstrated consistent success in assisting families to move through difficult treatment needs. By understanding the dynamics of recovery and maintaining a steadfast commitment to working with the families and believing in their ability, Project Connect provided the necessary support for families to make significant changes in their behavior. Early on when this program was evaluated, Project Connect demonstrated an effectiveness in reunifying families in half the time it took to reunify similarly situated families who had not received the program services. Children's Friend and Service was also able to have 25 Section 8 Housing Vouchers dedicated to the Project Connect program by the state housing authority. This has assisted the program in meeting some of the housing needs more expeditiously. There is also a Project Connect Coordinating Committee which provides a forum for collaboration, communication and coordination of services/resources between and among DCYF staff, substance abuse treatment providers, hospitals, community-based organizations and other State agencies.

The Vulnerable Infants Program (VIP) is established at the Women and Infants Hospital/Infant Development Center to provide care and support for drug exposed infants and their mothers. Program services include an array of assessments for both infants and mothers, referral and coordination of services, development of individualized treatment plans and training for Court, state and community agencies. The DCYF participates on the VIP Advisory Committee which assists in the coordination of planning for reunification and ongoing family support for cases open to the Department.

- The Rhode Island Family Court has established a separate pilot court calendar for drug exposed infants born in Providence and Bristol Counties. The Department has a staff representative that sits on the Steering Committee. The Family Treatment Drug Court program identifies and assesses drug-exposed infants, provides substance abuse treatment for parents, develops comprehensive multi-disciplinary case plans for families, ensures intensive case monitoring and provides for frequent court supervision of court orders, case plan compliance and progress in treatment. Treatment programs referred to by the Family Treatment Drug Court include: day treatment, residential treatment, SStarbirth program for mothers and children, and outpatient services.

The RIte Care provider Neighborhood Health Plan of Rhode Island (NHPRI) recently began implementing a program that will proactively target foster children in order to ensure that they receive medical and behavioral health services shortly after placement by contacting social caseworkers and substitute care providers to complete a medical / behavioral health needs assessment, and then to follow up on it by making recommendations for appropriate referrals. If children are already receiving treatment, the health plan staff will assist workers and substitute care providers in maintaining treatment without interruption. The goal of this program is to reduce the need for emergency room visits and behavioral health crises by providing proactive treatment for foster children.

Additionally, the Department is working with DHS to prepare a waiver to allow foster parents with income at or below 200% of the federal poverty level to enroll in the RIte Care program. The goal of this initiative is to increase the number of foster homes available to Rhode Island foster children. The waiver will also recommend that RIte Care parents whose children are removed due to their (the parents) substance abuse issues would be allowed to remain on RIte Care for 6 months after the child(ren)'s removal from the home. The purpose of this amendment is to allow the substance abusing parent to be able to seek RIteCare covered substance abuse treatment and facilitate a more timely reunification process.

Providence Center/RI Foundation Parenting Program
Designed to assist families where a parent has a mental health problem and/or who are cognitively limited and likely have a history with DCYF. The program has English and Spanish speaking clinical staff, services are provided up to one year, and comprehensive treatment plans are tailored to the clients. Treatment plans could include home visits, dyadic therapy with parents and children, parent support groups, coaching, playgroups, psychological and or psychiatric testing, and coordination and provision of developmental and educational services for children as needed.

Visitation

Families Together Therapeutic Visitation Program through the Providence Children's Museum operates in all four of the DCYF regional office locations, allowing visitation program consultants to be out-stationed into the four regions. The Families Together program consultants work with supervisors and caseworkers to develop stronger capacity for supervising visitations, providing education on child development and behavior management; and providing helpful, constructive feedback to parents following visitations. The Families Together also provides pre-service trainings on therapeutic visitation for Department and residential provider staff.

Through this approach, there has been an enhanced awareness regarding the value of visitation as an integral part of permanency planning. The program serves approximately 70-80 families annually, but this is estimated to be only about 17% of the families that could benefit from the Families Together connection.

The Families Together program also received national recognition this year as one of 15 finalists selected from across the country in the prestigious Innovations in Government Award presentation offered through the Kennedy School of Government at Harvard University. This recognition has already generated interest from other states. The Families Together Program Director has been invited to make a presentation for the Court Improvement Program in the State of New Jersey.

Care Management Teams
The creation of the Care Management Team (CMT) within each of the regional office locations offers a process of joining families, DCYF staff, and members of the community together in identifying and recommending options for meeting children's needs for placements, with the objective being to provide placements in close proximity to the family in the least restrictive setting. The CMT has been operating statewide since March 2002 and is responsible for planning and arranging for the service and placement needs of children and youth identified as high risk and in need of an intensive residential placement, or those children who are returning from higher end placements and are in need of a step-down structured environment or intensive community wraparound support.

When families and staff attending the Care Management Team meetings are unable to satisfactorily place a child or youth in an appropriate setting due to the necessary type or availability, etc., the child/youth may be referred to the Department's internal Resource Management Team (RMT). The Resource Management Team has two essential functions. They consider individual cases when every other recourse to find an appropriate in-home, in-state and/or contracted placement has not been successful and/or they receive a specific request from a CMT for a "purchase of service" placement i.e. an out-of-state residential treatment facility; or, lastly when Family Court orders a placement to an out of state facility or a type of care that does not currently exist. The RMT also reviews all placements on the continuum of care and from data received from the CMTs as to need and availability. The Resource Management Team is the planning tool for new programs based on the age, disability, behavior, etc. of presenting youth.

Placement Services
According to the state's Permanency Profile, in 2002, there were 1,235 children in relative and non-relative foster care which is about 52% of the number of children in placement. There are a variety of foster care settings in which a child may be placed upon entering the care of the

Department. Unfortunately, there is a critical lack of foster family homes available to meet the needs of children in care. As a result, children may be placed in other types of placements that are not ideally matched to the needs of the child, but rather due to the lack of appropriate resources. There is currently underway a recruitment effort to increase our placement capacity and to develop resources that more appropriately meet the needs of children in placement, especially the adolescent population.

In accordance with federal and state laws, the Department is first obligated to explore if there are suitable relatives who may be caregivers. According to our data profile, 23.5% of the children are placed in relative homes. Based on our estimates, and anecdotally, we have always believed our placement percentages to be much higher than the data profile suggests. The difference may be attributed to our use of kinship care. When you combine children in relative with kinship care (i.e. child specific and known previously to the child) homes in Rhode Island, our percentage of children placed in relative and kinship care is greater than non-relative placements. According to "point in time data" for January 8, 2004, of all children placed in family settings, 612 or 52.6% are in relative/kinship homes compared to children in non-relative and private agency homes at 551 or 47.4%.   Caregivers are provided with a monthly board payment that is based upon the child's needs and the foster parent's ability to meet those needs. For foster parents who work, the Department will pay the cost of day care for foster children in their care.

The Department provides a wide array of placement services and levels of care throughout an expanding and developing continuum for children and youth in substitute care. When a child or youth is not able to be placed in a foster care setting, they may be placed in a shelter or a group home. If they have a higher level of treatment need, they may be placed in a residential treatment program. Throughout the system of care, there are the following types of placement services:

- Therapeutic foster care
- Emergency shelters
- Managed Networks
- Group Homes
- Staff secure group homes
- Supervised Apartments
- Independent living programs
- Residential counseling Centers
- Intensive residential placement

Therapeutic Foster Family Care
The Department has contracts for specialized foster care homes as well as several "purchase of service" foster care programs providing a therapeutic home for 202 children and youth between the age range of birth to 21.   These specialized programs include the Groden Center, Boys and Girls Town, Family Service, Mentor, Family Resources, Casey Family Services, North American Family Institute, Community Care Services and Devereux.

Purchase of Services Placements
When services are needed beyond the range of the contracted services and placements, the Department purchases services through individualized contracts with providers that are able to deliver the higher intensity level of care necessary for some of the Department's population. These services are typically more expensive than the array of contracted services available. As

of September 30 of this year, the number of youth in purchase of service (POS) placements was 328, but 32% of these are in therapeutic foster care settings in Rhode Island. Only 30 of the youth, or 9%, are in distant out of state placements. The remaining 59% of the youth are in residential placements that are close to home – the majority (32%) are in-state and the rest are nearby in Massachusetts.

The Department's commitment and steady movement toward reducing the number of out of state placements over the past few years has continuously shown progress in the increasing number of therapeutic foster homes and increased in-state capacity.

Two new community-based residential treatment programs are in the process of being developed. Youth Services International and Jammat Housing-Turning the Corner have been selected to establish two 8 bed programs; one for boys and one for girls. The girls' program is expected to be operational in two to three months and the boys' program in six to nine months. There is also an intensive residential treatment program as a hospital step-down for 16 youth planned for next year.

Managed Networks
In April 2000, the Department contracted with four community agencies for a managed network of residential services. The Network, made up of three child welfare agencies and the state's largest community mental health center, is a partnership to provide placements and wrap-around services to all youth and families referred. The array of services include staff-secure placements, group homes, staffed apartments, foster care, independent living and home based services. Core principles include:
- serving youth referred under a 'no reject/no eject' model,
- least restrictive level of care,
- ensuring community partnership,
- central clinical/case manager to follow a youth,
- greater flexibility in service provision, and
- greater accountability through a continuous quality improvement program.

The QI program for the Network measures 12 goals; 10 that are youth specific and two are program specific goals. To date the Network has provided the Department with reports demonstrating this model can accept and manage all youth referred, can successfully move youth through less restrictive levels with a significant percentage achieving reunification and decrease lengths of stay in residential programs. Outcomes to date represent that 68% discharged to reunification, adoption, or an Independent Living Program. One hundred percent enrolled in school or vocational program, received clinical services, 80% met all of their service plan goals, 90% demonstrated improved life skills and 11% experienced a psychiatric hospitalization (a decrease from 27% over the prior year).

Service Accessibility — Gaps/Barriers
The Department convened several focus groups involving wide participation from community-based social service , youth groups and other stakeholders. These focus groups were helpful in identifying issues relating to service accessibility from their perspectives and experience. The list below is a quick reference to issues identified by these focus groups:

- Currently there is no feedback loop on contracts so that if staff have an issue with the provider, other than sharing it with the program monitor, there is no formal way for staff to have input in the process.
- There is a need for "targeted recruitment" to maintain children in their own communities.
- There is a need for non-offending parents groups to be aware and accommodating for parents with limited English literacy.
- Language appropriate services.
- There are not sufficient services or resources to address the needs of parents with MR and/or dual diagnosed parents.
- Insufficient intensive home-based reunification services.
- Lack of transportation, especially in South County area.
- Insufficient services for developmentally delayed children or children with serious emotional disturbances.
- Lack of therapeutic recreation and respite.
- CEDARRS will identify child as eligible for services but services are not available or there is a long waiting list for identified services.
- Need more outreach and tracking programs for youth, as well as more contract flexibility within existing services for providers to meet needs not in their targeted area when vacancies exist.
- Barriers associated with youth/children who are in this country illegally, especially for youth coming out of the RITS – need to address the status of youth sooner.
- Insufficient treatment services available for non-adjudicated sexual offenders.
- Lack of sufficient services/placements for sexual offenders needing step-down programs from residential treatment and/or the RITS – the Department currently has 40 such beds with qualified sexual abuse treatment services.
- Lack of services for Lesbian, Gay, Bi-sexual, Transgender (LGBT) youth – the Department does provide linkages for youth with community resources, and staff in residential programs are trained to work with the youth and other residents on issues of diversity.

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2. Discuss how effective the State has been in meeting the title IV-B State plan requirement to provide pre-placement preventive services designed to help children at risk of foster care placement remain safely with their families.

Special Health Care Needs Service Assessments and Referrals

A new program that was certified by the State of Rhode Island in 2001 is known as CEDARRs: Comprehensive Evaluation and Diagnostic Assessment, Referral and Re-evaluation. The CEDARR Service Centers are administered by the state's Medicaid Authority, which is the Department of Human Services. The CEDARRs provide state-wide choice and access for families with a child who has special needs to obtain objective and comprehensive assessments of their service needs combined with necessary basic supports throughout the process. All services are family-centered and strength based, designed to empower families to make their own informed choices about desired treatment. Four family centers are operational but remain

in development in terms of access by DCYF families. Ongoing collaboration with the DHS is addressing training, referral, access and availability for families that do not have a legal status with the Department.

Children's Mental Health
The Department of Children Youth and Families is the responsible agency for mental health services to children; and over the past year, DCYF in partnership with the Department of Human Services, has restructured its Children's Intensive Services (CIS) outpatient counseling/support service for children with Serious Emotional and/or Behavioral Disturbances (SED). New certification standards have been released with a new payment structure and a utilization review component. The DCYF and its stakeholders have long recognized the need for a community and home-based mental and behavioral health program to meet the needs of children with serious emotional and/or behavioral disturbances (SED). These children often present with mental health issues that threaten to result in placements at more restrictive living arrangements, including settings which may be out of their home and/or out of their community. The primary focus of Children's Intensive Services (CIS) is to provide an array of clinically oriented, community based services and supports, to allow the child to be maintained in the least restrictive living arrangement and whenever possible, in a family setting. This service is different in type from a single service, such as outpatient therapy, in that it is geared to address the multiple, complex needs of the child and family.

During the past fiscal year, approximately 2,200 children/youth were enrolled in the current CIS program. As a result of reviewing over 1,000 current CIS cases, it is expected that the capacity of the new CIS program will be close to 2,000 children/youth and their families on an annual basis. The former CIS providers operated under a contract. The establishment of a certification process and issuance of Certification Standards provide the basis for future determination of provider agencies eligible to receive payment for provision of CIS. Other changes include a move to four distinct clinical levels of care, clinical standards for entry into each of the four levels, and strict Utilization Review/Prior Authorization conducted by a CIS Utilization Review Team. This is a Medicaid out of plan service. As such, the only payment mechanism in place is Medicaid. This may impact DCYF involved children/youth living at home who are not Medicaid eligible at the time they are seeking CIS. Three major commercial insurers in the state have agreed to develop a CIS-like program and offer it to their enrollees; however, until such time as commercial insurers are willing to purchase this new CIS from Certified Vendors, only Medicaid eligible youth are guaranteed coverage, if they meet the clinical standards. The contractor will ensure that there will be no waiting lists and there will be no "catchment area" so that families will have their choice of CIS providers.

Additionally, the Department has refined its definition for SED which will assist in making sure that CIS is meeting the needs of the population for whom it is designed. This change will also promote development of expanded capacity throughout outpatient counseling in lesser levels of intensity to meet the needs of children/youth who do not meet SED criteria. The outcomes intended in restructuring the CIS program and providing greater clarification regarding the condition of serous emotional disturbance is that the system will be better functioning to ensure:
- maintenance of the child in the least restrictive living arrangement,
- continuity of care,
- improved coordination of care,
- reduction of inpatient psychiatric hospital admissions and readmissions,

- child focused and family centered intervention,
- appropriate and timely service provision,
- improved functioning by child as measured by CGAS and CAFAS, and
- parent/child satisfaction.

There are multiple required aggregate data elements and outcome measures to be captured and reported to DCYF on an ongoing basis as part of the quality assurance and performance measurement for the CIS programs.

Community-Based Social Service Agency Programs
The Department also funds an array of community-based programs that are not specifically clinical, but are designed to promote social and emotional well-being for children and families. Funding for these programs is through general revenue and federal grants. Some of these service and program types are:

> Children's Trust Fund (Prevention focused) Programs
> Project Family
> Comprehensive Emergency Services (CES)
> Project Early Start
> Specialized parent aide services
> Juvenile Justice Host Home Project
> Implementation of Article 23 (Requires preventive community-based services for adolescent youth prior to seeking a wayward/disobedient petition in Family Court)
> Parent Support Network
> Family Based Renewal Program (John Hope)
> Youth Diversion and Outreach and Tracking
> Child and Adolescent Service System Program (CASSP)

The state provides family preservation and intense preservation services for families in crisis. Family preservation programs provide in home services that includes family/child(ren) assessments, case management, crisis stabilization and referral, parent aide/education and respite daycare. Families may receive services three to five times per week dependant upon the intensity of need.

The intensive family preservation (ISP) programs provide similar services but have a different legal status. Families who are participating in the intensive family preservation programs have been investigated by Child Protective Services and have a finding of child abuse/neglect. The referral to the IFP is in lieu of an ex-parte petition for removal from home. The families meet the legal criteria for ex-parte but agree to participate in the program. Agencies reported that 75% of the children participating in these programs remained in the home at point of discharge.

- The Comprehensive Emergency Services (CES) program provides twenty four (24) hour emergency services, seven (7) days a week for those families who are experiencing a crisis due to issues of child abuse, neglect, and dependency. The voluntary services are directed towards maintaining the children in the home and de-escalating the presenting problem. The CES program is designed to provide services for a period of sixty (60) days. The CES program is available statewide through eight (8) community based agencies. Program Services 1070 families. Services include family assessment, crisis stabilization and referral

to counseling, medical and substance abuse evaluation, housing, shelter, and economic assistance. Of the families served, less than 3% of families were opened to the Department during or at time of closing. Overall 86% of the families showed improvement utilizing the North Carolina Family assessment scale.

- Project Early Start is a comprehensive early intervention program for economically disadvantaged families with children from newborn to three years old, who are at risk for developmental, health and social problems. The project provides both home-based and center-based activates for parents to enhance their parenting skills and address the social factors that determine the child at-risk. Services include a family assessment completed by a case manager. Assessments include evaluating the cognitive and emotional needs of child, parenting skill level, and comprehensive health care. Home based services provide information on parenting, child development, home management and family inter-action skills. Center based activities provide parenting and play groups. Of the families served by Early Start 20% of the families were open to the Department.

- Parent Support Network had developed primarily to assist families of children with serious emotional disturbance who had no formal involvement with the child welfare agency. However, there is greater appreciation now for the trauma associated with child abuse/neglect and the impact that involvement in the child welfare system has on children and their families. The Parent Support Network is providing additional support for families through assistance with the Care Management Teams to help parents understand the role and responsibilities of the Department, as well as their participation in the process. This past year, the program served 101 families with 110 children involved in DCYF. Many of the families are looking for assistance because they've been told to file a wayward/disobedient petition on their teenagers.

- The Department is also funding a Juvenile Justice Host Home Project which has proved effective in diverting youth from Family Court on Wayward/Disobedient petitions. This program holds great promise for the Department. Currently it is operational in the southern part of the state in Region III working with local police departments and a community mental health center to assist families earlier with an effective intervention aimed at keeping youth in their own homes or in their community. Host homes are recruited within the community to provide necessary respite for youth and their families. Mediation is provided by clinicians from the local community mental health center who work with the police and help to link families to other supportive services.

  This Juvenile Justice Project has demonstrated effectiveness in diverting families from filing wayward/disobedient petitions which would require families to go to Family Court, and ultimately, perhaps, have youth placed within DCYF care. The Department expanded this program last year, allowing a second clinician to be hired. Thirty-one families are currently receiving service. The "Article 23" Program is based on the same operating principles as this unique program.

- Project Family is an intensive family preservation program providing limited upfront services. This program works to prevent some families from becoming formally involved with the Department. The families are identified through an investigation and they typically require more intensive services than can be provided in a Comprehensive

Emergency Services program. This program, Project Family, is focused on preservation services and remains involved with a family for a year if necessary in order to link them with the appropriate and necessary support. This past year, 23 families with 50 children received services.

- The Family Support Project is a program with the Department of Psychiatry at the Rhode Island/Hasbro Children's Hospital. This program is providing a family-centered intervention in situations where child sexual abuse has been disclosed. The program is in the process of developing a standardized intervention promoting effective treatment through a family-centered intervention as quickly as possible, and support for the family and extended family, as a means of aiding the healing process for the child/youth. Twenty-nine families with 33 children are currently receiving service. This program is entering its third year, and preliminary data from its controlled clinical trial is quite positive representing that the trends are all moving in the right direction for child well-being and healthy functioning.

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3. Discuss how effective the State has been in meeting the title IV-B State plan requirement to provide services designed to help children be placed for adoption, with a legal guardian, or if adoption or legal guardianship are determined not to be appropriate for a child, in some other planned, permanent living arrangement.

When children in foster care are unable to return to their biological family, adoption is the preferred permanency option. Over 45% of Rhode Island's children are achieving the goal of adoption within 24 months of entry in to care. Longitudinal studies by our Yale Data Analytic Center demonstrate that the median length of stay to adoption is 20 months. Foster parents adopt about 80% of the children in our system. The number of adoptions over the last eight years peaked at 332 in 1996 but has been consistently above 250 each year since 1999.   Our numbers increased following a number of changes that allowed us to move cases more quickly through the system. These changes included the implementation of a court mediation process, as well as legal and practice changes as a result of ASFA.

The introduction of concurrent planning as an integral part of the Department's family centered practice initiative is a key strategy that encourages collaboration with families towards achievement of greater consensus on placement and earlier permanency decisions for children. The family centered practice demonstration project, which will be implemented on a statewide basis within the next few months, focuses on developing strength based assessments and case plans that engage families in planning and decision making without compromising issues of child safety and well being.

In recognition that there is a critical need for therapists who are competent and skilled in the dynamics of the adoption process and the relationship issues in the adoption triad, the Department is exploring the development of a training curriculum and certification requirements that would establish adoption training as a specialty for mental health practitioners. There have been preliminary discussions with the School of Social Work at Rhode Island College, the Child

Welfare Training Institute and one of the managed care plan's behavioral health providers to assist in developing this certification process.

Funding through IV-B, part 2 supports the work of Adoption Rhode Island, an agency solely committed to adoption promotion and support services. It works in partnership with the Department's Adoption Resource and Training Unit to identify adoptive families and match children appropriately, provide education and support for individuals and couples who wish to build or expand their family through adoption. All children available for adoption in the Department must be registered with Adoption Rhode Island. This agency provides adoption preparation services for children for adoption, holds adoption parties, coordinates the Tuesday's Child program with the Department and a local television station and co-sponsors with the Department an annual adoption conference. The agency also assists in training activities to increase the knowledge and skills of professionals who work with waiting children and adoptive families regarding adoption practice; and, work to strengthen the partnership with DCYF and other community providers. Adoption Rhode Island is working with the Department to develop the training curriculum for certifying clinicians as adoption specialists in an effort to further support adoptive families. This past year, Adoption Rhode Island provided services to 226 families and 159 children.

As referenced earlier, in response to recommendations from the 1999 Governor's Commission to Study the Placement of Children in Foster an Adoptive Care, the Department consolidated staff who train foster and adoptive families. The unit was restructured and additional clinical training specialist positions were added under the supervision of a Chief Casework Supervisor. Concurrent planning was added to the curriculum as of January 2001. In recognition of the fact that foster parents adopt most children, the Department moved in January 2002 to providing dual training for foster and adoptive parents. The Adoption/Foster Care Preparation and Support Unit currently provides training for all relative and non-relative foster care and adoptive providers. This unit also prepares home studies for adoptive families and provides case specific consultation, training and support to Family Service workers in the area of adoption.

Special Needs
The Department provides adoption subsidies for children who qualify based upon special needs criteria, such as, age, racial or ethnic background, physical, mental or emotional disability or membership in a sibling group. Medical assistance, day care, and respite services may be included in a child's adoption subsidy. The adoption services unit is also responsible to review subsidies on an annual basis and to assist adoptive families with referral for community services. With the increasing numbers of subsidized adoptions in the Department (2500 plus), this unit is not sufficiently staffed to meet the needs of the growing number of families receiving adoption subsidy.

The Special Needs Adoption Coalition (SNAC), co-chaired by the Chief of the Adoption/Foster Care Preparation and Support Unit and the Executive Director of Adoption Rhode Island, was formed in 2001 to address issues affecting special needs adoptions. Represented by members of the adoption community, this group meets regularly to identify strategies and system needs that would provide a strong safety net of support for children and families both during their preparation for adoption and after finalization.

During the past several years a number of community agencies have begun to offer specialized adoption services, and the current array of services is quite broad. However, these agencies cannot meet the current need and families and children find themselves on waiting lists. While it is possible to find counseling slots in other community agencies, those clinicians are most often not skilled in handling adoption issues. SNAC has identified the lack of appropriate adoption services as one of the major reasons for adoption disruptions and dissolutions. This needs assessment is helping to support the Department's effort to develop an adoption specialist certification program that will provide training to qualified applicants on adoption-related issues and treatment techniques.

In September, 2002 the Department also initiated an adoption policy committee comprised of Department staff and members of the adoption community to work collaboratively with the Department to provide recommendations for updating Department policy and practice in the area of adoption. Recommendations were made from three sub-committees in the areas of adoption preparation, adoption placement and post placement and adoption finalization. Recommendations have been incorporated into draft policy that will be brought back to the group and to other Department staff before promulgation. Adoption regulations will also be adapted based upon the recommendations of the committee. The group also made several training recommendations that will be considered when training for the new adoption policy is implemented.

Self-Sufficiency Preparation for Older Youth
As referenced earlier, the Department held a youth focus group in August in preparation for the 2004 CFSR. Thirty-six youth participated, providing an opportunity for several issues to be identified as well as recommendations. As a result, the Department's consultant on youth development services has sent a reminder to all staff that the Rhode Island Youth Advisory Board has developed a pamphlet that covers the areas addressed at the focus group and the variety of locations the pamphlet is available to them. The pamphlet answers 34 of the most frequently asked questions by youth entering care. It addresses their rights and responsibilities, case planning, Administrative Review Unit responsibilities, chain of command, Department and specific youth community resources available, expectations of staff, visits with parents and siblings, etc. It is a comprehensive and well written resource. Additionally, our consultant involves youth in pre-service training for new staff during their orientation to the Department.

The Department plans on organizing and including in our Program Improvement Plan (PIP) a youth and group care "provider forum" to discuss behavioral consequences, privacy issues, hiring practices, etc. Family Service, Inc. is one provider that has agreed to co-sponsor the event with us and to assist in the planning. We also plan to develop and include in our PIP a mechanism to prepare youth for their Administrative Review involvement and adapt the structure of the review meetings to address some of their additional concerns about privacy.

The Department is also actively involved in promoting self-sufficiency skills and independence for older youth who are preparing for adulthood. There are about 840 youth aged 16 and older in DCYF out-of-home placement, and the efforts by the Department to ensure adequate services to assist them in preparation for independent living are expanding, but we are still not capturing how well overall the Department is able to impact this need. One organization that is critical in

this endeavor is Work Opportunities Unlimited. This is an organization that trains, coaches, and assists in finding jobs for individuals with significant barriers to employment. In July of 2002 they launched a youth division in Rhode Island serving youth who completed either the Chafee Life Skills Program through the Rhode Island Council of Resource Providers for Children, Youth and Families (RICORP), or the RIFPA Life Skills program. They measured 12 outcomes including:

- Total number funded and served = 20,
- Total number of youth that graduated in July of 2003 = 11,
- Total number of youth that elected to continue to participate for another 6 months to be able to graduate successfully from Work Opportunities Unlimited – 7, etc.

The medium wage earned per hour was $8.00. A sample of the employer partnerships developed include Miriam Hospital 3 workers, AVEX/T.F. Green Airport, InTown YMCA, D.E.M., PETsMart, etc. The mission in the youth division at Work Opportunities Unlimited is "help young people learn to make positive decisions".

The Department also works with AS 220, which is an arts program providing opportunities to youth in the community aimed at developing artistic talents and helping youth to learn appropriate and effective ways to express themselves. The Independent Living Program has established a contract which provides a stipend for youth who demonstrate initiative and interest after a period of volunteer involvement. These youth are given the opportunity to work with adult artists and entrepreneurs to develop skills in art and business and to eventually produce a product which can be sold for profit. Currently, 20 youth are involved with the program. Over the year, 20 to 40 youth will be engaged in the process.

Life Skill Assessment and Curriculum – A standardized life skills assessment instrument and curriculum is provided for all youth in out-of-home care, aged 16 and older. The assessment and curriculum were developed by the Daniel Memorial Institute and are software-based. The assessment covers 14 skill areas in the ninety question/interview format. After the interview assessment has been completed, the results are entered into the computer which produces a report indicating the percentages of correct answers the youth achieved within each category. An additional report, the Skill Plan Printout, provides a goal and corresponding strategies for every question the youth answered wrong.

The curriculum, Curriculum and Lessons for Attaining Self-Sufficiency (CLASS) provides life skill instructors with 78 lesson plans, handouts, sample activities, pre and post tests, and other tolls to assist staff in teaching life skills classes in the same 14 categories that have been assessed. These 14 skill areas include topics on budgeting, housing and career planning. Additionally, there are field trips scheduled and guest speakers supplement the CLASS curriculum. Youth attend weekly sessions for six hours per week for 20 weeks. Transportation is provided by the Life Skills Center by employing foster parents who are hired for that purpose. DCYF Family Service Unit staff use the assessment results to develop the Transitional Living Plan.

Youth residing in foster care are assessed using the same instrument, through referral to the Life Skills Center, a program contracted to by the Rhode Island Foster Parents Association. Upon receipt of a referral from the Family Service Unit worker, the foster parent or from the youth

directly, the Life Skills Center staff schedule an appointment to complete the assessment and to enroll the youth in the Life Skills Center program.

Upon completion of the Life Skills Center Program, youth attend a graduation ceremony, which includes a banquet, speakers and a disc-jockey for dancing. Youth are encouraged to invite their families, foster families, social workers and other supportive people in their lives. They are awarded with a completion certificate and a completion stipend of two-hundred dollars. Approximately 60 youth have graduated from the Life Skills Center program during the year.

F. Agency Responsiveness to Community

1. Discuss how effective the State has been in meeting the requirement to consult and coordinate with external community stakeholders in the development of the State's Child and Family Services Plan (CFSP). In responding, discuss how the concerns of stakeholders are addressed in the agency's planning and operations and their involvement in evaluating and reporting progress on the agency's goals.

Community Planning Forums

Over the past three years, the Department of Children, Youth and Families has been actively involved in organizing and promoting public forums that have been focused on the agency's operation, and with the goal of identifying achievable changes in practice that would effectively shift the agency's reliance on high-end residential treatment programs to more community-based, family-centered support for children and families. Each of these initiatives has provided the framework for the agency's commitment to engaging external community stakeholders and promoting opportunities for better programming and improved relationships. The Department has reported on each of these activities in the Annual Progress and Services Reports for its Child and Family Service State Plan.

In July 2000, the Department joined with two key legislative leaders in sponsoring the *Open Forum on Placement Issues Involving DCYF Children and Youth*. This two day forum involved stakeholders across the provider system, including social service agencies, community mental health agencies, representatives of the state's two psychiatric hospitals, biological families, foster and adoptive families, DCYF staff and key staff from other state agencies. The purpose of this forum was to assist in identifying critical strategies for revising the system of care relating to service and support needs for children and families, and particularly addressing the needs for children in out-of-home care. Each of the issues identified in this two day forum were easily linked and compatible with the Department's five goals which were shared with all participants.

It became quite apparent as a result of the follow-up work from the Open Forum that the systems issues were larger than any one department, and required a level of commitment that would involve all three branches of government: Executive, Legislative and Judiciary. In April 2001, the Governor's office launched this larger initiative as the Rhode Island System of Care Task Force. This task force worked over a year and a half with three key subcommittees that looked

at 1) Current Reality, 2) Foster Care Recruitment, Training and Retention, and 3) the Ideal System of Care. There were also regularly scheduled larger meetings that were open to the public for further discussion on strategies to move the system toward stronger community-based support for children and families. The Task Force issued its report on January 2, 2003 entitled *Toward an Organized System of Care for Rhode Island's Children, Youth and Families*. Rhode Island's new governor Donald Carcieri embraced the report and instructed the Children's Cabinet to make implementation of the strategies contained within the report a priority.

As a result, an Implementation Steering Committee has been formed with the two co-chairs being the Director of the Governor's Office on Community Affairs and a former co-chair of the Rhode Island System of Care Task Force. Quarterly meetings are being held at which the Department provides updates on its activities related to the priority strategies which include a specific focus on psychiatric hospital utilization and discharge planning, and Medicaid Resource maximization. The Department maintains a comprehensive contact list of stakeholders representing providers, biological families, foster families, adoptive families, legislators, other state agency representatives, as well as representatives of the judiciary. At the most recent meeting of the Implementation Steering Committee, representatives of provider and family organizations offered to further assist in promoting public awareness of and involvement in the Department's efforts through their own networking resources. This offer was readily accepted.

This past June, the Department sponsored a three day retreat to develop strategies for implementing Family-Centered Practice-Neighborhood by Neighborhood. Staff throughout the Department and community stakeholders participated in this activity which was led by The Network for Child Safety, a federally funded Resource Center, which is run out of the Public Children's Services Association of Ohio. As a result of this endeavor, the Department has developed four blueprints for implementing Family-Centered Practice within each of the geographic regions. The primary focus of this initiative is to recruit and support foster families within each region, so as to maintain youth within their own communities whenever possible if they need to be placed outside of their home for any reason.

Foster Parent Town Meetings
In addition to the public forums detailed above, the Department meets yearly with foster parents at a town meeting to solicit their involvement and feedback. The Association, along with many of the providers, community stakeholders, judiciary, and representatives of the Narragansett Indian Tribe contributed to the development of this Statewide Assessment, and a focus group was held with youth involved with the agency. Attempts to bring together a focus group of biological parents who have cases opened for abuse and/or neglect was unsuccessful but an intern is still working on putting that focus group together. Through these public forums and the CFSR process, the Department has solicited the input of the community at large. When the Statewide Assessment is complete it will be posted on our web site and a letter will also be sent to the general community asking for their input.

Youth/Parent Partnership

This past year, the Department formed a Youth/Parent and DCYF Partnership to begin evolving a process of having families involved in designing services that will be consumer-driven, and to inform DCYF policies for these services. Many of the participants in this Partnership were

involved in the Department's restructuring of the Children's Intensive Services (CIS) program. The Youth/Parent Partnership membership includes 15 parents and 5 adolescents as a core, but the subcommittees attract wider participation. The Partnership is coordinated by the Parent Support Network of Rhode Island which facilitates meetings and subcommittee activities. Three subcommittees were formed to work on identified priorities including:

- Promoting Awareness and Interest in Respite Services

- Developing Recommendations for Improvement in Outpatient Services

- Planning and Promoting a Children's Summit for May is Mental Health Month

Over the year, the Respite Subcommittee has developed a comprehensive definition for respite care which may be able to inform larger inter-departmental considerations for developing respite-like services to meet a variety of caregiver needs.

The Partnership has also been asked to assist in the development of a new service designed to provide emergency mobile treatment services which will support efforts to stabilize youth in placement settings and reduce the likelihood of disruption or psychiatric hospitalizations. A May is Mental Health Month Children's Summit is planned for May 2004 with a focus on furthering implementation efforts for the System of Care across the continuum.

Training Initiatives
A partnership with community groups is also a resource for promoting training initiatives. The partnership is comprised of the Child Welfare Training Institute, John Hope Settlement House, the Office of Training and Development at the Department of Administration, Children's Friend and Service, the Providence Children's Museum, Rhode Island Council of Resource Providers (RICORP), the Department of Human Services, the RI Council of Community Mental Health Organizations, RI Parent Information Network, Family Services, Inc, Providence College, and Elizabeth Buffum Chase House (Domestic Violence). This particular group's objectives are to enhance communication between and among their organizations responsible for delivering training in the area of child welfare, to increase the sharing of resource and knowledge about training activities such as training needs and potential trainers, and to explore collaboration in the development of trainers and training initiatives.

There are also several focus groups that continuously contribute to the development of new training initiatives. These are comprised of groups from within the department, Rhode Island College and other colleges, as well as community groups. For example, the following training initiatives were developed and held as a result of focus groups: Coping with Prison Visitation, Child Development, Domestic Violence, and Advanced Family Assessment. Participants in the focus groups from outside of the department were also invited to attend the resulting training events. The training initiatives noted here were initially piloted as a 3 hour segment, then a 1 day training. Once those evaluations were reviewed they were then developed in more depth, usually resulting in a 3 day training program.

Relationship with Family Court

The Department and Family Court have engaged in a deliberate effort to foster effective communication and improve services for children, youth and families which has improved our relationship at the Executive level. Our Chief Legal Counsel and Senior Associate have scheduled meetings with the Chief Judge and other judicial staff to tackle issues from both perspectives. As a result, some positive changes have occurred and others continue to be developed. Family Court has added two (2) rooms in the Providence Courthouse with computers, phones and fax for Department staff to meet and confer on cases, retrieve phone and email messages, document decisions, develop case plans, etc. This enables staff to more effectively use their time awaiting hearings. Time to visit with families and children has been hampered over the years by time spent in Court, but this working partnership is leading to a resolution that will result in calendars scheduled for two hour blocks. Workers would then have a limited number of hours to plan on being in Court and can freely schedule the remainder of the day to complete their family contacts and services.

The Family Court has expanded to include specialized courts; i.e., the Family and Youth Drug Court, Truancy Court, and Re-Entry Court for youth exiting the Rhode Island Training School. Staff acknowledge the benefit of specialization, especially, in the area of drug use and truancy which affects so many of our children, youth and families. The challenge accompanying them is the additional demand on staff for court appearances, time and insufficient legal staff representation. In addition, there are occasionally court orders placing further demands on workers; i.e., to transport a child to and from school, etc. The result is that staff at all levels of the Department feel that Family Court judges do not understand the workload expectations and roles of workers in general, and especially during this time of severe budget projections and economic strain. At the same time, Family Court judges question the aggressiveness of the Department's allocation of funds for sufficient staff and placement resources.

<blockquote>

2. Discuss how effective the State has been in meeting the State plan requirement to coordinate its services with the services and benefits of other public and private agencies serving the same general populations of children and families.

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Network Development

As referenced in the section on services and resource development, the Department established a statewide network of contracted vendors to provide a continuum of services for children and youth referred into the network. This Network was begun in April 2000. The premise of the operation was to ensure that youth were able to be assessed, treated and supported as they progressed through adjustments in their level of care. This continuity of care and wraparound support for the youth, as well as emphasis on outreach and engaging their families has evolved in the past three years and is gaining in support and recognition throughout the Department. As a result of this endeavor and recommendations from the Rhode Island Task Force Report, *Toward and Organized System of Care*, the Department has begun to develop Regionally-based networks. The first one has just begun in the Providence Region. Though this activity is very

much a work in progress, it is the direction in which the Department is heading in an effort to ensure continuity of care and promote better quality of care for children and Youth.

Within the agency's contracts, there is language that promotes and supports collaboration and coordination of services on the community-level among providers. Such coordination would include case management activities to ensure that families are not overwhelmed by multiple service representatives that may hold different perspectives on the families' needs. The Department has been working steadily over the years with its providers to ensure that the care plans for children and youth are developed to promote optimum care and treatment, without sending conflicting messages. Again, this practice change is continuing to evolve, but the experience with Family-Centered Practice is helping to solidify this approach agency wide and among the all providers.

Inter-Agency Collaboration

In November 2000, the Department of Children, Youth and Families began enrolling the majority of its children in substitute care into the state's managed care program, RIte Care. This process was completed in May 2002, representing a substantial collaboration and partnership with the Department of Human Services, the state's Medicaid Authority. The Assistant Director of Children's Behavioral Health at DCYF and the Associate Director for Health Care Financing at DHS with their staff meet regularly to discuss and monitor program activity. Neighborhood Health Plan of Rhode Island, with Beacon Behavioral Health Strategies, is the managed care plan that handles health and behavioral health care needs for all of the DCYF involved children and youth. Regular monthly meetings are scheduled with representatives of NHPRI/Beacon and DCYF to monitor program activity and identify necessary changes are improvements in the operation.

The Department is also working collaboratively with the Department of Mental Health, Retardation and Hospitals, Division of Developmental Disabilities to provide appropriate support and care for youth in need of out of home placement in order to prevent these youngsters from having to be sent out of state. Simultaneously, the Department is preparing to develop necessary capacity in state in order to return those developmentally delayed youth who are currently receiving care outside of Rhode Island back to their communities. This work is being done in concert with MHRH/DDD.

The Department uses a program funded by the Department of Human Services (DHS) for parenting teens, who cannot live with their parents or legal guardians. The New Opportunity Homes were developed in response to welfare reform in 1996 with the enactment of Temporary Assistance for Needed Families (TANF). DCYF assisted and collaborated with DHS in the design and development of this initiative. The program provides several levels of supervision in a homelike setting for mothers and their children from birth to 18 months old. Community-based service providers operate the New Opportunity Homes in apartments located throughout the state, each provider has one of the three levels of care in their program. The first level is the most intense providing 24 hours a day supervision of the mothers enrolled. The services include case management, parent education, and educational support to mothers. The second level provides a group home setting with intermittent supervision, case management, parent education

and educational advocacy. The third level maintains the mother and baby in an individual apartment setting with intermittent supervision, case – management, parent education and educational advocacy.

The Department is also part of a Statewide Prevention Planning Committee for a 3 year, $9-million grant which is working on developing a comprehensive statewide prevention plan focusing on underage drinking. The Children's Cabinet is overseeing this initiative, with the Department of Mental Health, Retardation and Hospitals (MHRH) as the lead agency having been awarded the State Incentive Grant by the Center for Substance Abuse Prevention (CSAP). MHRH is also leading another grant initiative which DCYF is participating in aimed at supporting and enhancing efforts to enforce laws prohibiting the sale of alcohol to or the consumption of alcohol by minors.

Safe Streets Providence

A joint program with DCYF's Juvenile Probation and Parole staff , the Adult Probation and Parole staff and the City of Providence Police Department is known as "Safe Streets Providence." This project is aimed at reducing and preventing violent crime committed by youthful offenders by providing intensive monitoring during evening and weekend hours for high risk youthful offenders between the ages of 16 and 25. Participants in this program have a history of violent crime, gang involvement, and/or substance abuse. They may be active probationers with pending violations of probation, candidates for temporary community placement, or early release. If the specialized conditions of probation are completed, or through re-assessment, a probationer can be classified as low-risk and transferred to supervised probation. Probationers move through the program in stages toward less intensive supervision and participate in developing their own discharge plans toward being able to maintain themselves as productive members of the larger community. In the six month period from January to June 2003, 110 youth between the ages of 15 and 21 were referred to the program from Family Court and the Rhode Island Training School. Eleven cases were successfully closed during this period.

Family Court Initiatives

As referenced earlier, the Family Court has established a separate pilot Court calendar for drug exposed infants born in Providence and Bristol Counties. The Family Treatment Drug Court program identifies and assesses drug-exposed infants, provides substance abuse treatment for parents, develops comprehensive multi-disciplinary case plans for families, ensure intensive case monitoring and provides for frequent Court supervision of Court orders, case plan compliance and progress in treatment. A DCYF staff representative sits on the advisory committee for this Family Treatment Drug Court.

The Family Court also established a Juvenile Drug Court a few years ago. This Court initiative combines the authority of the Court with a therapeutic regimen to foster rehabilitation of and accountability in substance abusing juveniles and their families. The program goals are to reduce delinquency and alcohol or substance dependence among juvenile offenders, as well as to integrate the juvenile justice system with the therapeutic community in order to maximize a juvenile's opportunities and likelihood for success. A DCYF staff representative sits on the advisory committee for this specialized Court, as well.

> 3. Does the agency have any agreements in place with other public or private agencies or contractors, such as juvenile justice or managed care agencies, to perform title IV-E or IV-B functions? If so, how are services provided under the agreements or contracts monitored for compliance with State plan requirements or other program requirements and accurate eligibility determinations made, where applicable?

Not applicable.

> 4. Citing any data available, discuss how effective the State has been in meeting State plan requirements for determining whether children are American Indian and ensuring compliance with the Indian Child Welfare Act.

The Department does meet with representatives of the Narragansett Indian Tribe for purposes of discussing issues relative to the Department's compliance with the Indian Child Welfare Act. To date, the Tribe/State Committee does not have a signed agreement. However, there is general agreement that Tribal child welfare cases will be handled on a concurrent, rather than exclusive jurisdictional basis. This has worked well in practice between the Tribe and the Department. The Associate Director for Child Welfare and Child Protective Services is the Department's liaison to the Narragansett Tribe. There is a free flow of information between the Department and Tribe.

Wenonah Harris, the Narragansett Indian Tribal Child Advocate, although a vital part of our CFSR Oversight Committee has not been able to attend many meetings but has had input in the process and Assessment. The Tribe reports that their workings with the Department are proceeding quite well. There are a few instances where staff have needed education and correction as it pertains to the Indian Child Welfare Act and regular education review of those issues for staff is recommended. The Tribal Child Advocate also reports a good working relationship with the Department's legal staff in court proceedings pertaining to Indian youth. A formal link between the Tribe and our Independent Living services and initiatives has been made to enhance Indian youth's access to such services and grants.

G. Foster and Adoptive Home Licensing, Approval, and Recruitment

> 1. Discuss how effective the State has been in meeting the requirement to establish and maintain standards for foster family homes, adoptive homes, and child care institutions in which children served by the agency are placed.

The Department of Children Youth and Families has maintained standards for foster family homes, adoptive homes, and child care institutions since 1979. Child care regulations were last updated in 1987, and foster home regulations were last revised in 1998. As referenced earlier in the section of quality assurance, the Department is currently in the process of revising standards for day care homes, group care facilities and foster care homes to ensure they meet all of the requirements of ASFA. Historically, adoptive and relative foster homes were not licensed, only approved. However, mechanisms are being put into place whereby pre-adoptive homes will be licensed. The only difference at this time is the fire inspection. This inspection is to be added and linked to RICHIST. This will include private adoption homes as well.

The Department has had difficulty with recruiting potential foster or adoptive parents, largely due to the inability of the Department staff to provide face-to-face contacts with potential families as well as provide the ongoing support for new families. Personal engagement is the best way to recruit, sustain and support foster parents. As stated earlier, the 2 year licenses should assist with this dilemma by reducing the licensing workload demand and increasing the time staff can spend with families.

Our licensing workers have an average caseload of 160 families, close to three times the number that would be optimum. The Child Welfare League of America recommends a standard of 50 – 60 families per worker. The federal regulations call for foster families to be visited at least 4 times a year, our licensing workers are only able to make one visit a year.

There is a difference between Rhode Island criminal records checks and the federal guidelines regarding drug offenses. Under federal guidelines, drug offenses constituting a felony are considered a disqualifier for the past five years. Under Rhode Island law the Department disqualifies applicants if they are currently arrested or have been convicted at all for felony drug offenses.

> 2. Citing any data available to the State, discuss how effective the State has been in meeting the State plan requirement to ensure that the State's licensure standards are applied equally to all foster and adoptive homes and child care institutions that serve children in the State's care or custody.

The Department has successfully applied the same quality standards to relative, non-relative, kinship care and adoptive homes and work is continuing on developing a uniform licensing packet for all providers. There was a loss of 40 relative providers when the same licensing standards were applied to all caregivers.

Feedback from Departmental staff requested a resource packet for foster parents, particularly relative and kinship care providers. This packet is under development and will include important telephone numbers, expectations for licensing, school lunch programs, WIC, foster board payment, etc. The packet will be developed in English and Spanish.

RICHIST is able to provide reports in advance of expiration dates so that foster homes needing renewal are provided with the attention needed. However, a lack of foster licensing staff has had a direct impact on the timeliness of renewals.

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3. Citing any licensure or safety data available to the State, discuss how effective the State has been in meeting the State plan requirements to conduct criminal background clearances on prospective foster and adoptive families, including those being licensed or approved by private agencies in the State. How does the State address safety considerations with respect to the staff of child care institutions and foster and adoptive families (if the agency has opted not to conduct criminal background clearances on foster care and adoptive families)?

Every applicant, including those in private child placing agencies must be cleared by background checks with the FBI, Bureau of Criminal Identification (BCI) and DCYF. Hard copy forms are used for this clearance. Given the volume of background checks that are needed, efficiency in this area is average. There has also been inconsistency between the local police departments throughout the state and their willingness to conduct searches in a timely fashion. The Department is researching the feasibility of purchasing a portable, digital fingerprint scanner to expedite this process.

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4. Citing any data available to the State, discuss how effective the State has been in meeting the State plan requirement to recruit and retain foster and adoptive families that represent the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed, including the effectiveness of the State's official recruitment plan.

Recruitment

The goal of foster parent recruitment is to ensure that sufficient numbers of qualified foster families are available to meet the needs of the Department and the children it serves, and to allow for careful matching and planned placements to meet the best interests of every child in need of foster care. As approximately 80% of all DCYF children who are adopted are adopted by their

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foster parents, it is critical that initial foster placements be established with consideration for a child's long term needs.

Systemically, the Department has consolidated the operations of foster/adoptive parent recruitment, training and licensing under the supervision of the Associate Director of Child Welfare. This change provides greater continuity and support, as well as the potential for increased training capacity for foster and adoptive parents. However, there is concern that the recruitment responsibilities are over burdening within the current structure. Presently, the Department employs one full-time foster parent recruiter. The recruiter is responsible for developing a foster parent recruitment plan including general and targeted recruitment goals; developing print and media advertising campaigns; conducting community education and public awareness activities; responding to foster parent inquiries; processing of submitted foster parent applications and background checks; and the referral of completed application packets through the Licensing Division for assignment and review.

There is a significant gap in the number of inquiries being made and the actual responses with complete application packets. The reasons for this disparity are not known, but warrant further examination in order for the Department to better understand what changes may be necessary to encourage people who are interested in becoming foster parents to follow through in the application process. Recognizing that recruitment, support and retention of foster families is not a "one or two" person job, discussions have begun with regional staff to establish speakers bureaus to be available for community groups and public forums such as provider fairs in order to have more opportunities to promote foster parent recruitment.

Outcomes

These combined activities resulted in the following outcomes for the first eleven months of FY2003:

688 Inquiries (applications mailed out)
134 Applications Returned
117 Referred to Licensing for assignment/review

An inquiry refers to a foster parenting informational and application packet which is sent out or distributed to a person who is requesting additional information. These individuals may be interested simply in gathering additional information about the foster care process for future consideration or may be seriously interested in becoming a foster parent at this time. Inquiries typically occur through the following means:

- Telephone call
- Walk-in request
- E-mail request
- Recruitment Events – meetings, booths, displays

A returned application refers to a completed application which is submitted by a foster parent applicant.

Referrals to Licensing refers to those submitted applications which are referred to Licensing for assignment and continuation of the foster care licensing process after the initial clearances

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(Bureau of Criminal Identification (BCI) and DCYF) are completed and the application information is reviewed and accepted.

Nationally, response rates range from about 10% to about 50%. Most seem to be in the 10%-25% range although different systems have different definitions of what constitutes an inquiry and what constitutes an application. (Figures from Karl Brown of Casey Family Programs National Center for Resource Family Support). In 2003, Rhode Island's DCYF had a response rate of 19%. While this is well within the national norm, our goal is to improve this rate by improving our follow-up on inquiries and applications.

Retention activities

Retention of foster parent homes is a continuing concern for the Department. As reported in the System of Care Task Force Report *Toward an Organized System of Care* released in January 2003, an alarming decline in the total number of licensed foster homes had become evident over a period of approximately five years. A variety of factors including increased adoption by foster parents, changes in licensing regulations and other specific reasons for closing have significantly curtailed retention. However, the Department has also been moving steadily in recent years toward improving its relationship with foster parents. These improvements have reduced placement disruption and increased stability and consistency for children in foster care. Significant improvement is also noted between the Rhode Island Foster Parent Association and DCYF in establishing a partnership toward improving the foster care system and supporting and maintaining high quality foster homes.

The Rhode Island Foster Parents Association was formally incorporated in 1995 with funding from DCYF. A volunteer board of directors governs the Association, the mission of which is to provide education and other forms of support to families that provide substitute care, and to the community-at-large, in order to further the cause of children who have been separated from their parents. The Rhode Island Foster Parents Association (RIFPA) represents approximately 1,100 foster families and 2,000 foster children in the care of DCYF. One of the programs that promotes guidance and support for new foster parents and serves as an avenue for retention is the Mentor Program. This program provides twenty-four (24) hour support through the Help Line for all licensed foster parents. Mentor assignments are made on the basis of individual need. Some families benefit by having a mentor from their local community. Others require a mentor with special skills, such as experience with children with special behavioral or health care needs. Some mentors rely on telephone contact, others visit their families, and some plan "get togethers" so more families can meet. A mentor may be in contact with a particular family on a daily basis, weekly or monthly, depending on the family's situation at anytime except the off hours that they specify. Mentors also must sign a confidentiality agreement to protect privacy. On average, the Mentor Program's 24 hour help-line receives 170 calls per month.

The RIFPA also produces a monthly newsletter that provides information regarding the Association and DCYF activities. The Newsletter is distributed to all licensed foster homes as well as DCYF and other agencies upon request. This publication has a mailing list of approximately 1,300 foster homes and businesses. The Newsletter is the main source of information received by foster families regarding any news or upcoming events or training. This is a major source of recruitment, and we expect that it also supports retention. However, the Department does not have any formal evaluation mechanism for the effectiveness of any of these efforts.

Additionally, the RIFPA has received a $5,000 competitive grant from the National Foster Parents Association, which is being matched through its DCYF contract to develop five regionally-based foster parent support groups which will begin in January 2004. The Providence-based support group will have bi-lingual staff. There will be an outside facilitator who will be coordinating and leading these groups. The RIFPA will ensure that the design and delivery of the support functions will be responsive to the differing needs of relative vs. non-relative caregivers if participants want to break out into smaller groups.

Adoptive Parent Recruitment
Unfortunately, DCYF has a significant need for more African American adoptive parents. We have had a number of families who speak only Spanish come forward for licensing, and the Department is partnering with community churches in a "faith based initiative" for further recruitment and training opportunities.

The Department also contracts with Adoption Rhode Island (ARI) as well as the Urban League of Rhode Island for recruitment of adoptive/foster homes. These agencies maintain a photographic listing of children on their Website. We have a Tuesday's Child program with the top rated local television station, an Adoption Conference is held annually, and the Department with the adoption promotion agencies plan several events throughout the year to publicize the need for adoptive families. Recruitment for special needs children tends to be on an as needed basis. We explore resources within the child's community of origin, educational setting, social circles, etc. Some state funds also go to the Rhode Island Foster Parent's Association (RIFPA) for recruitment.

We have performed targeted, geographical recruitment. We advertise in majority and minority newspapers, on bus tails, TV and radio spots. Letters of Interest have been issued for placements of adolescents and teens. Department staff routinely and successfully look to relatives and kinship care as the least restrictive setting for children on their caseloads. Existing research on recruitment strongly suggests that the approval of a significant number of quality foster homes results from on-going and diverse activities that maintain a positive awareness of foster care over at least one year's time. It has been noted that individuals think about becoming foster parents for about one full year before they actually contact an agency. Constant exposure, over an extended period of time, to the idea of becoming a foster parent will stimulate thought and result in making an inquiry call. These recruitment activities focus on both the long term process of increasing general public awareness of the role of foster parents and the licensing process and the immediate need for increasing our available pool of qualified foster parents.

Community awareness of adoption, interest in adoption and recruitment of families is stimulated through a variety of activities, including:
- Print Advertising – 33 daily, weekly, monthly, and special interest publications;
- Television Advertising;
- Tuesday's Child Television Program – Top rated local television station;
- Tuesday's Child Quarterly Newsletter;
- Cable TV Information Program – Families First
- Radio Advertising;
- Advertising on RIPTA busses;

- Adoption Conference – a yearly two-day offering a wide variety of workshops and presentations about adoption;
- Informational Booths and Presentations;
- Monthly Informational Meetings;
- AdoptUSKids website;
- ARI website;
- A photo listing of available children;
- Recruitment Parties; and
- Targeted Recruitment Efforts -- reaching specific populations, such as minority groups, pediatric nurses, and potential foster parents for specific groups of children, such as developmentally disabled children, medically fragile children, and adolescents, with foster parent recruitment materials.

We are also working with our MIS staff on the correct identification of kinship care homes in our RICHIST system, and would utilize a payment of "zero" for families that opt to utilize resources through the Family Independence Program (FIP) rather than foster board payment. It is expected that this approach will enhance recruitment of other family members to become kinship providers.

Adoption Retention

In adoption, retention activities center on encouraging families during the waiting period and supporting them through the placement process and post-placement period. DCYF's Clinical Training Specialists who train and study the pre-adoptive homes, provide contact and support for their families. ARI holds three adoption parties each year. These well-attended events provide an opportunity for waiting families to see waiting children and to meet families who have already adopted. Community agencies (Adoption Rhode Island, Casey Family Services, Children's Friend and Service, etc.) offer support for adoptive and pre-adoptive parents in the form of discussion groups, counseling and counseling groups. Adoptive Families in Action is a social, support and advocacy group organized and run by adoptive parents.

> 5. Citing any data available to the State, discuss how effective the State has been in meeting the State plan requirement to recruit and use adoptive families for waiting children across State or other jurisdictional boundaries. In responding, consider relevant agency policies, timeframes for initiating recruitment activities, and specific methods.

The Department is moving to increase the opportunities for cross-jurisdictional placements for Rhode Island's waiting children. We are presently involved in discussions with our neighboring state of Connecticut and Massachusetts with the purpose of facilitating inter-state recruitment and placements. Registering waiting children on the AdoptUSKids website is a priority and staff will be receiving training in that process. Currently we have four children registered on the AdoptUSKids website funded by the Children's Bureau. We are requesting training and

technical assistance from AdoptUSKids regarding better understanding and use of their website, as well as having them provide information at the ARI adoption conference scheduled for March.

Section III – Data Profiles

I. CHILD SAFETY PROFILE	Calendar Year 2000						Calendar Year 2001						Calendar Year 2002					
	Reports	%	Duplic. Childn.[2]	%	Unique Childn.[2]	%	Reports	%	Duplic Childn.[2]	%	Unique Childn.[2]	%	Reports	%	Duplic Childn.[2]	%	Unique Childn.[2]	%
I. Total CA/N Reports Disposed[1]	7,573		11,531		9,042		7,451		11,369		9,008		7,211		10,772		8,627	
II. Disposition of CA/N Reports[3]																		
Substantiated & Indicated	2,194	29.0	3,361	29.1	3,001	33.2	2,227	29.9	3,319	29.2	2,961	32.9	2,185	30.3	3,247	30.1	2,906	33.7
Unsubstantiated	5,188	68.5	7,909	68.6	5,848	64.7	5,060	67.9	7,800	68.6	5,851	65.0	4,864	67.5	7,300	67.8	5,539	64.2
Other	191	2.5	261	2.3	193	2.1	164	2.2	250	2.2	196	2.2	162	2.2	225	2.1	182	2.1
III. Child Cases Opened for Services[4]			1,911	56.9	1,643	54.7			1,884	56.8	1,621	54.7			1,703	52.4	1,447	49.8
IV. Children Entering Care Based on CA/N Report[5]			822	24.5	702	23.4			815	24.6	699	23.6			854	26.3	733	25.2
V. Child Fatalities[6A]					3	0.1					5	0.2					1	0.0
STATEWIDE AGGREGATE DATA USED TO DETERMINE SUBSTANTIAL CONFORMITY																		
VI. Recurrence of Maltreatment[7] [Standard: 6.1% or less)					203 of 1,634	12.4					173 of 1,624	11.0					156 of 1,532	10.2
VII. Incidence of Child Abuse and/or Neglect in Foster Care[8] (for Jan-Sept) **[Standard: 0.57% or less]**					55 of 3,304	1.66					54 of 3,327	1.62					38 of 3,443	1.10

FOOTNOTES TO DATA ELEMENTS IN CHILD SAFETY PROFILE

Each maltreatment allegation reported to NCANDS is associated with a disposition or finding that is used to derive the counts provided in this safety profile. The safety profile uses three categories. The various terms that are used in NCANDS reporting have been collapsed into these three groups.

Disposition Category	Safety Profile Disposition	NCANDS Disposition Codes Included
A	Substantiated or Indicated (Maltreatment Victim)	"Substantiated," "Indicated," and "Alternative Response Disposition Victim"
B	Unsubstantiated	"Unsubstantiated," "Unsubstantiated, Other than Intentionally False Reporting " and "Unsubstantiated Due to Intentionally False Reporting"
C	Other	"Closed-No Finding," "Alternative Response Disposition – Not a Victim," "Other," and "Unknown or Missing"

Alternative Response was added starting with the 2000 data year. The two categories of Unsubstantiated were added starting with the 2000 day year. In earlier years there was only the category of Unsubstantiated

1. *The data element, "Total CA/N Reports Disposed," is based on the reports received in the State that received a disposition in the reporting period under review. The number shown may include reports received during a previous year that received a disposition in the reporting year. Counts based on "reports," "duplicated counts of children," and "unique counts of children" are provided.*

2. *The duplicated count of children (report-child pairs) counts a child each time that (s)he was reported. The unique count of children counts a child only once during the reporting period, regardless of how many times the child was reported.*

3. *For the column labeled "Reports," the data element, "Disposition of CA/N Reports," is based on upon the highest disposition of any child who was the subject of an investigation in a particular report. For example, if a report investigated two children, and one child is found to be neglected and the other child found not to be maltreated, the report disposition will be substantiated (Group A). The disposition for each child is based on the specific finding related to the maltreatment(s). In other words, of the two children above, one is a victim and is counted under "substantiated" (Group A) and the other is not a victim and is counted under "unsubstantiated" (Group B). In determining the unique counts of children, the highest finding is given priority. If a child is found to be a victim in one report (Group A), but not a victim in a second report (Group B), the unique count of children includes the child only as a victim (Group A). The category of "other" (Group C) includes children whose report may have been "closed without a finding," children for whom the allegation disposition is "unknown," and other dispositions that a State is unable to code as substantiated, indicated, alternative response victim, or unsubstantiated.*

4. The data element, "Child Cases Opened for Services," is based on the number of victims (Group A) during the reporting period under review. "Opened for Services" refers to post-investigative services. The duplicated number counts each time a victim's report is linked to on-going services; the unique number counts a victim only once regardless of the number of times services are linked to reports of substantiated maltreatment.

5. The data element, "Children Entering Care Based on CA/N Report," is based on the number of victims (Group A) during the reporting period under review. The duplicated number counts each time a victim's report is linked to a foster care removal date. The unique number counts a victim only once regardless of the number of removals that may be reported.

6. The data element "Child Fatalities" counts the number of children reported to NCANDS as having died as a result of child abuse and/or neglect. Depending upon State practice, this number may count only those children for whom a case record has been opened either prior to or after the death, or may include a number of children whose deaths have been investigated as possibly related to child maltreatment. For example, some States include neglected-related deaths such as those caused by motor vehicle or boating accidents, house fires or access to firearms, under certain circumstances. The percentage is based on a count of unique victims of maltreatment for the reporting period. The count also includes fatalities that have been reported on the Agency File, which collects non-child welfare information system data.

7. The data element, "Recurrence of Maltreatment," is defined as follows: Of all children associated with a "substantiated," "indicated," or "alternative response victim" finding of maltreatment during the first six months of the reporting period, what percentage had another "substantiated," "indicated," or "alternative response victim" finding of maltreatment within a 6-month period. The number of victims during the first six-month period and the number of these victims who were recurrent victims within six months are provided. This data element is used to determine, in part, the State's substantial conformity with Safety Outcome #1.

8. *The data element, "Incidence of Child Abuse and/or Neglect in Foster Care," is defined as follows: Of all children who were served in foster care during the reporting period, what percentage were found to be victims of maltreatment. A child is counted as having been maltreated in foster care if the perpetrator of the maltreatment was identified as a foster parent or residential facility staff. Counts of children maltreated in foster care are derived from NCANDS, while counts of children placed in foster care are derived from AFCARS. The observation period for these measures is January-September because this is the reporting period jointly addressed by both NCANDS and AFCARS. For both measures, the number of children found to be maltreated in foster care and the percentage of all children in foster care are provided. This data element is used to determine, in part, the State's substantial conformity with Safety Outcome #2.*

Additional Footnotes
(none)

Rhode Island States Child and Family Services Review Data Profile, June 20, 2003

II. POINT-IN-TIME PERMANENCY PROFILE	Federal FY 2000		Federal FY 2001		Federal FY 2002	
	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
I. Foster Care Population Flow						
Children in foster care on first day of year	2,181		2,122		2,160	
Admissions during year	1,409		1,493		1,582	
Discharges during year	1,348		1,227		1,378	
Children in care on last day of year	2,302		2,414		2,383	
Net change during year	+121		+292		+223	
II. Placement Types for Children in Care						
Pre-Adoptive Homes	35	1.5	38	1.6	27	1.1
Foster Family Homes (Relative)	504	21.9	488	20.2	522	21.9
Foster Family Homes (Non-Relative)	745	32.4	747	30.9	713	29.9
Group Homes	773	33.6	879	36.4	860	36.1
Institutions	31	1.3	27	1.1	23	1.0
Supervised Independent Living	71	3.1	88	3.6	99	4.2
Runaway	110	4.8	121	5.0	122	5.1
Trial Home Visit	0	0	0	0	0	0
Missing Placement Information	0	0	1	0.0	1	0.0
Not Applicable (Placement in subsequent year)	33	1.3	25	1.0	16	0.7
III. Permanency Goals for Children in Care						
Reunification	1,213	52.7	1,239	51.3	1,199	50.3
Live with Other Relatives	11	0.5	14	0.6	1	0.0
Adoption	364	15.8	374	15.5	363	15.2
Long Term Foster Care	217	9.4	183	7.6	229	9.6
Emancipation	281	12.2	342	14.2	332	13.9
Guardianship	9	0.4	5	0.2	5	0.2
Case Plan Goal Not Established	6	0.3	9	0.4	1	0.0
Missing Goal Information	201	8.7	248	10.3	253	10.6

Rhode Island States Child and Family Services Review Data Profile, June 20, 2003

II. POINT-IN-TIME PERMANENCY PROFILE (continued)	Federal FY 2000		Federal FY 2001		Federal FY 2002	
	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
IV. Number of Placement Settings in Current Episode						
One	717	31.1	852	35.3	861	36.1
Two	438	19.0	478	19.8	527	22.1
Three	290	12.6	337	14.0	284	11.9
Four	219	9.5	216	8.9	199	8.4
Five	163	7.1	162	6.7	130	5.5
Six or more	470	20.4	361	15.0	379	15.9
Missing placement settings	5	0.2	8	0.3	3	0.1
V. Number of Removal Episodes						
One	1,463	63.6	1,510	62.6	1,518	63.7
Two	515	22.4	574	23.8	522	21.9
Three	202	8.8	207	8.6	214	9.0
Four	84	3.6	88	3.6	87	3.7
Five	20	0.9	18	0.7	18	0.8
Six or more	18	0.8	16	0.7	21	0.9
Missing removal episodes	0	0	1	0.0	3	0.1
VI. Number of children in care 17 of the most recent 22 months[2] (percent based on cases with sufficient information for computation)	594	43.1	658	43.1	643	44.5
	Number of Months		**Number of Months**		**Number of Months**	
VII. Median Length of Stay in Foster Care (of children in care on last day of FY)	15.1		15.5		14.0	

II. POINT-IN-TIME PERMANENCY PROFILE (continued)	Federal FY 2000		Federal FY 2001		Federal FY 2002	
	# of Children Discharged	Median Months to Discharge	# of Children Discharged	Median Months to Discharge	# of Children Discharged	Median Months to Discharge
VIII. Length of Time to Achieve Perm. Goal						
Reunification	747	7.1	815	5.0	935	6.5
Adoption	168	29.9	167	25.9	185	25.6
Guardianship	42	26.1	35	14.7	30	18.2
Other	191	21.0	161	24.7	180	18.0
Missing Discharge Reason	133	10.9	10	7.3	16	6.9
Missing Date of Latest Removal or Date Error [3]	67	NA	39	NA	32	NA
Statewide Aggregate Data Used in Determining Substantial Conformity	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
IX. Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percentage was reunified in less than 12 months from the time of the latest removal for home? (4.1) **[Standard: 76.2% or more]**	506	63.3	581	68.8	635	66.2
X. Of all children who exited care to a finalized adoption, what percentage exited care in less than 24 months from the time of the latest removal from home? (5.1) **[Standard: 32.0% or more]**	64	37.7	74	43.8	85	45.0
XI. Of all children served who have been in foster care less than 12 months from the time of the latest removal from home, what percentage have had no more than two placement settings? (6.1) **[Standard: 86.7% or more]**	1,200	72.6	1,348	78.8	1,478	82.3
XII. Of all children who entered care during the year, what percentage re-entered foster care within 12 months of a prior foster care episode? (4.2) **[Standard: 8.6% or less]**	293	20.8 (67% new entry)	312	20.9 (65% new entry)	303	19.2 (68% new entry)

Rhode Island States Child and Family Services Review Data Profile, June 20, 2003

III. PERMANENCY PROFILE FIRST-TIME ENTRY COHORT GROUP	Federal FY 2000		Federal FY 2001		Federal FY 2002	
	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
I. Number of children entering care for the first time in cohort group (% = 1st time entry of all entering within first 6 months)	419	61.4	456	65.3	485	68.60
II. Most Recent Placement Types						
Pre-Adoptive Homes	0	0	0	0	1	0.2
Foster Family Homes (Relative)	107	25.5	99	21.7	124	25.6
Foster Family Homes (Non-Relative)	117	27.9	147	32.2	150	30.9
Group Homes	118	28.2	137	30.0	139	28.7
Institutions	33	7.9	38	8.3	31	6.4
Supervised Independent Living	9	2.1	13	2.9	13	2.7
Runaway	34	8.1	19	4.2	27	5.6
Trial Home Visit	0	0	0	0	0	0
Missing Placement Information	0	0	0	0	0	0
Not Applicable (Placement in subsequent yr)	1	0.2	3	0.7	0	0
III. Most Recent Permanency Goal						
Reunification	310	74.0	349	76.5	380	78.4
Live with Other Relatives	2	0.5	1	0.2	0	0
Adoption	10	2.4	11	2.4	13	2.7
Long-Term Foster Care	4	1.0	4	0.9	9	1.9
Emancipation	15	3.6	17	3.7	19	3.9
Guardianship	1	0.2	2	0.4	3	0.6
Case Plan Goal Not Established	1	0.2	1	0.2	0	0
Missing Goal Information	76	18.1	71	15.6	61	12.6

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III. PERMANENCY PROFILE FIRST-TIME ENTRY COHORT GROUP (Continued)	Federal FY 2000		Federal FY 2001		Federal FY 2002	
	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
IV. Number of Placement Settings in Current Episode						
One	221	52.7	238	52.2	263	54.2
Two	94	22.4	112	24.6	134	27.6
Three	32	7.6	53	11.6	51	10.5
Four	25	6.0	28	6.1	16	3.3
Five	9	2.1	10	2.2	11	2.3
Six or more	38	9.1	15	3.3	10	2.1
Missing placement settings	0	0	0	0	0	0
V. Reason for Discharge						
Reunification/Relative Placement	126	77.3	163	89.1	177	90.8
Adoption	2	1.2	3	1.6	1	0.5
Guardianship	3	1.8	5	2.7	2	1.0
Other	14	8.6	12	6.6	14	7.2
Unknown (missing discharge reason or N/A)	18	11.0	0	0	1	0.5
	Number of Months		Number of Months		Number of Months	
VI. Median Length of Stay in Foster Care	15.4[4]		12.9[5]		14.3[6]	

Rhode Island States Child and Family Services Review Data Profile, June 20, 2003
FOOTNOTES TO DATA ELEMENTS IN THE PERMANENCY PROFILE

[1]The FY00, FY01, and FY 02 counts of children in care at the start of the year exclude 40, 59, 40 children, respectively. They were excluded to avoid counting them twice. That is, although they were actually in care on the first day, they also qualify as new entries because they left and re-entered again at some point during the same reporting period.   To avoid counting them as both "in care on the first day" and "entries," the Children's Bureau selects only the most recent record. That means they get counted as "entries," not "in care on the first day."

[2]We designated the indicator, *17 of the most recent 22 months,* rather than the statutory time frame for initiating termination of parental rights proceedings at *15 of the most 22 months*, since the AFCARS system cannot determine the *date the child is considered to have entered foster care* as defined in the regulation. We used the outside date for determining the *date the child is considered to have entered foster care*, which is 60 days from the actual removal date.

[3]Dates necessary for calculation of length of time in care in these records are chronologically incorrect. N/A = Not Applicable

[4] This First-Time Entry Cohort median length of stay was 15.4 months in FY00. This includes no children who entered and exited on the same day (who had a zero length of stay).   Therefore, the median length of stay was not affected by any same day children.

[5] This First-Time Entry Cohort median length of stay was 12.9 months for FY01. This includes 5 children who entered and exited on the same day (who had a zero length of stay). Such children do not actually belong in AFCARS submissions because they do not meet the AFCARS definition of having been in foster care for at least 24 hours. If these children were excluded, the median length of stay would be 13.4 months.

[6] This First-Time Entry Cohort median length of stay was 14.3 for FY02. This includes 5 children who entered and exited on the same day (who had a zero length of stay).   Such children do not actually belong in AFCARS submissions because they do not meet the AFCARS definition of having been in foster care for at least 24 hours. If these children were excluded, the median length of stay would be 15.3 months.

Section IV - Narrative Assessment of Child and Family Outcomes

Instructions:

To complete the narrative assessment for each data comparison and outcome measure, State agencies should do the following:

1. Describe and compare any changes to data over time, the reasons for those changes, the factors affecting the numbers, and the effect on the outcomes of safety, permanency, and well-being.

2. Describe the additional data, case review, or interview results that could explain the reasons for the numbers or outcomes.

3. Discuss each item even if no change is detected and describe whether or not the lack of change is a desirable outcome.

4. For the data that are to be measured against the national standards, include a comparison of the State's data for the period under review to the national standard and make a determination of conformity. Describe the issue or factors that may have affected the item being in conformity or not.

5. For each outcome, determine if it is a strength, a need, or evidence of a gap in programs or services. Include a description of the efforts, planned or implemented, to address the identified needs or gaps.

6. Use the exploratory questions to thoroughly address each item and to evaluate how effective the State is with regard to each outcome.

A.   Safety

Outcome S1:   Children are, first and foremost, protected from abuse and neglect.
Outcome S2:   Children are safely maintained in their homes whenever possible and appropriate.

Based on examination of the safety data elements on the safety data profile in section III, and the State Child and Family Services Plan (State IV-B plan), please respond to the following questions.

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1. **Trends in Safety Data.** Have there been notable changes in the individual data elements in the safety profile in Section III over the past 3 years in the State? Identify and discuss factors that have affected the changes noted and the effects on the safety of children in the State.

An examination of the Safety Data shows a slight decline in the number of reports, dispositions, openings and placements while there is a corresponding increase in the number of early warnings (screen outs) during the same time period. The National trend demonstrates a slight increase in reports.

According to Rhode Island Kids Count Factbook, in the census of April 2000 there were 1,048,319 Rhode Island residents of which 24% or 247,822 were children under the age of 18. This is a 10% increase since 1990. At the same time, the number of children in the United States was the largest in history at 72.3 million. These national figures also represent a substantial increase in the child population over the last decade. Children now make up 26% of the U.S. population.

Children in Rhode Island at the start of the 21st century are older and more ethnically diverse. The largest increase in any age category was in the number of children in early adolescence (age 10-14) which increased by 20% between 1990 and 2000. In contrast, the number of children age 5 and under dropped by nearly 5% between 1990 and 2000.

While the number of children in Rhode Island and the nation continue to rise, along with the number of older more diverse children in Rhode Island, we experienced a decreased number of reports but there was a corresponding increase in Early Warnings (Screen Outs) over the same period of time. In 1997 the number of early warnings was 3,521 or 29.3% of all reports while in 2000 there were 4,547 early warnings or 38%.

The decreasing number of reports in Rhode Island may also be impacted by the emergence of neighborhood-based Family support/Resource Centers such as Family Renewal Center at John Hope Settlement House and the Family Support Center at Children's Friend and Service that

have provided increased accessibility to family support programs. Those programs focus on building strengths within families by improving environmental conditions, parenting skills, parent-child relationships and child well-being through increasing a family's ability to access community resources. As a result of this effort families serviced by the programs such as the Family Renewal Center at John Hope Settlement House showed a decrease in at-risk status as indicated by gains on the North Carolina Family Assessment Scale (NCFAS) summary scales. All five NCFAS scales assessing overall risk showed statistically significant decreases in at-risk status. Increased capacity of parents and families may prevent child abuse and neglect and ensure healthy child development.

Additionally, prevention programs funded through the Department's Community-Based Family Resource and Support Grant (Children's Trust Fund programs), provided service to 1,456 families with 1,972 children between the ages of birth to 10. Other programs funded by the State which were referenced earlier in the document are Project Early Start and Comprehensive Emergency Services. The Early Start program assists families with children between the ages of birth to three, primarily. This program works with families whose young children may be at risk for developmental delays due to environmental factors. This past year, 346 families with 617 children received services through this program. The Department's Comprehensive Emergency Services (CES) program served 1,097 families with 2,640 children.

RIte Care, Rhode Island's Medicaid managed care health insurance program, provides families on the Family Independence Program (FIP) and eligible uninsured pregnant women, parents, and children up to age 19 with comprehensive health care, and transportation to care. RIte Care has received national recognition and praise for its success. As Rhode Island families have better access to health care, there may be fewer incidents of neglect and abuse, thus, RIte Care may be a factor in the reduction in the number of investigations.   (See Child and Family Well Being for more information on RIte Care.)

The Child Protective Services Intake and Investigation functions remain centralized from receipt of a report of an allegation of abuse/neglect through investigation determination including investigations on any cases currently open to the Department. Reports of child abuse/neglect are received through the centralized Child Abuse Hot Line. The information is reviewed by a Child Protective Investigator and supervisor to determine if the information meets the criteria for an investigation. In order to rise to the level of an investigation, the information must involve a child under the age of 18 or under the age of 21 if that child resides in a residential facility or is in the custody of DCYF, and must meet at least one, but not all of the following criteria:

- Harm or substantial risk of harm is present

- A specific incident or pattern of incidents suggesting child abuse/neglect can be identified

- A person responsible for the child's welfare as defined by RIGL 40-11-2 (parent, guardian, foster parent, adult living in the home or any employee of a public or private

child care facility (home or center or residential facility) has allegedly abused/neglected a child

- A parent has transferred or assigned to a non-relative his/her rights and duties with respect to the permanent care and custody of a child under age 18 without a duly authorized decree or order of the court

- Allegations of sexual abuse of a child by another child

- A report alleges that a perpetrator of sexual abuse or serious physical abuse has access to another child in a family dwelling shall result in an investigation (Duty to Warn)

If a report meets the criteria for investigation, then a response time is assigned. Categories of response priorities have general criteria using the level of harm and risk to the child. An **emergency response** requires that the report be processed within ten minutes after the call is completed and is assigned to a field investigator within 10 minutes of being processed. An **immediate response** requires that the report be processed within one hour after the call is completed and is assigned for investigation within the work shift during which the call was received (the division operates 24 hours per day, 7 days per week rotating four shifts per day). A **routine response** requires that the report be processed within one hour of the completion of the call and is assigned for investigation within 24 hours.

Among the criteria for an emergency response is that a child is in imminent danger of physical harm or a child has died due to alleged abuse or neglect and there are other children in that family. Immediate response criteria includes reports involving children placed on a 72 Hour Protective Hold issued by a physician or nurse practitioner. All other reports in which there is minimal risk to the child are responded to within the routine response time.

All other reports regarding concerns for the well-being of children which do not meet the criteria to initiate an investigation are currently classified as "Early Warnings". That information remains in the electronic record for a period of two years, before being expunged. In some instances, such reports involving cases which are active for services with another division of the Department are also classified as Early Warnings and may result in action by the active worker to address or assess the information provided in the report. For example, a report may be received which alleges that children are not being properly supervised, but provides no specific incident. The report would be forwarded to the assigned Family Service Worker who would then address the allegations with the family, speak with all members and address the issue as appropriate. Repeated reports which constitute Early Warnings may be reviewed to upgrade to an investigation.

Child Protective Services is currently in the process of finalizing policy which would replace the Early Warning with a "Screen Out". Screen Outs would also involve information which does not rise to the level of an investigation, but would require that in those instances in which a family is

active with another division that the primary service worker must acknowledge receipt of the information and must document a response. It would also require that information deemed a screen out and referred to an outside agency, such as a police department, be documented as a screen out to law enforcement/other community agency. DCYF also investigates allegations of institutional abuse/neglect and those reports which do not rise to the level of an investigation, but involve licensing or program issues will be "screened out" to the active program monitor or licensing worker who then responds to the information, documenting the response. Screen Out reports will also be expunged after two years.

During the course of an investigation it is required by policy that personal contact be made with all of the children named in the report as well as any other children in the household. It is required that the investigator make every effort to locate and interview each child who resided in the household at the time of the alleged incident, whether or not that child is a subject of the report. If it is determined that a child who resided in the household at the time of the alleged incident now lives out of state, the investigator is required to make every effort to locate that child and facilitate an interview through the child welfare agency in that state. It is also required that every effort be made to identify the past and present whereabouts of each child who is a member of the family. Investigators are required to interview all alleged perpetrators and must make collateral contacts for additional information.

A child protective investigation must be completed within ten days of its commencement. Extensions may be granted by an administrator, but may not exceed thirty days in accordance with policy. In terms of adhering to time frames, much emphasis is placed on responding to reports in accordance with the designated response times, and it appears that those time frames are adhered to. With respect to completing investigations within the ten day period, there has been some difficulty in complying with that time frame. Investigations remain open while investigators await information from other agencies such as police departments, medical professionals and other collateral agencies. In some cases, children are evaluated by mental health professionals or may be interviewed by the Child Advocacy Center, which conducts and evaluates forensic interviews of child victims in conjunction with law enforcement. Information from these sources is critical to the completion of investigations and at times delays that completion. The decrease in number of Child Protective Investigators also impedes the ability to complete written work in cases as the result of the increased number of cases assigned to investigators on a weekly basis.

Child protective investigations which find a preponderance of evidence to indicate the allegations are forwarded to Intake. In those instances where risk is not assessed to warrant on-going involvement with the DCYF Family Service Unit, but service needs have been identified, referrals are made to community-based programs in an effort to address those needs, reduce risk, prevent future child welfare involvement and preserve the family unit. In cases in which the children are removed from the home, or risk to the children warrants continued DCYF involvement or legal action, the family is assigned to a Family Service Unit for on-going assessment and case planning.

In our 2000 CFSR pilot assessment we noted that the Department had made a change in 1999 raising the standard of proof necessary to indicate a case from credible evidence to a preponderance of evidence. The data profile demonstrates that we did not experience a decline in substantiated reports as a result of that change largely because the preponderance standard was being used even prior to the formal change in policy.

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2. **Child Maltreatment (Safety Data Elements I & II).** Examine the data on reports of child maltreatment disposed during the year by disposition of the reports. Identify and discuss issues affecting the rate of substantiated vs. unsubstantiated reports and factors that influence decision-making regarding the disposition of incoming reports.

Over the past several years, approximately 60% of reports alleging abuse/neglect have been screened-in for investigation in line with the National trend. Our response supports that, in this area, the State is effective in meeting its mandate to ensure the protection of children. It also indicates that reporters have a working knowledge of what constitutes child abuse/neglect under Rhode Island's State statues since the majority of reports are appropriate for investigation.

The indicated and unfounded rates in child protective investigations reflect the national norm. At this juncture we are not concerned about the ratios. Our reporting law, definitions and policies have not undergone any changes and our disposition rate has remained relatively stable with substantiation rates at 33.2% in 2000, 32.9% in 2001 and 33.7% in 2002.

The Department continues to offer and deliver education and training on the reporting law to professionals and others who request it or with whom we are collaborating on projects and/or programs. There appears to have been no decline in the number of requests and/or presentations, and Child Protective Services is currently launching a community training initiative aimed at providing outreach to the community to offer trainings with respect not only to reporting laws, but also to provide the community with information about the services provided by DCYF and how a case may make its way through the system. The initiative also seeks to form partnerships with community agencies toward identifying community based services which may be utilized in order to reduce risk and divert families from being opened for on-going DCYF services.

3. **Cases Opened for Services (Safety Data Element III).** Compare the cases opened for services following a report of maltreatment to the rates of substantiated reports received. Discuss the issues affecting opening cases following reports of maltreatment and reasons cases are or are not opened.

The Department has a child protective services system model that allows flexibility in response to child abuse/neglect reports based on the level of risk and safety identified during the investigation. Decisions to open a case to the Department or a community agency are based on a nationally recognized, research based, risk assessment system which the Department implemented in 1995. While the data provided in the Safety Profile show that more than half of the indicated cases are opened for services by DCYF, this number does not reflect referrals to community-based agencies and other interventions not requiring an opening to DCYF. Screening and Assessment staff in Intake receive all indicated cases of abuse/neglect and apply the risk assessment tool to determine the first level decision; i.e., whether to open the family to our agency. Once that determination has been made they apply the criteria for specialized community programs; e.g.., CES, Project Family, Project Connect, etc. to see if the family is an appropriate referral for those programs. They also determine whether the family is currently engaged in services in the community which can meet the needs of the family. They discuss the options with families, and in supervision, and a combination of factors and judgment are used to determine the final referral source.

We have recently contracted with the National Council on Crime and Delinquency (NCCD) to conduct a revalidation study of our research based risk assessment. This instrument was designed and implemented in 1995. In 2000, we reviewed every open/close decision that had been made since 1997 using the Risk Assessment tool, and we found exceptional adherence to policy and exceptional professional judgment was used when making exceptions to the policy. Consistent use of the tool combined with clinical judgment has provided consistency among staff in decision making as to opening a case to the Department or a community-based service. This revalidation by NCCD will ensure that the tool is still current for assessing risks, given changing characteristics of families and more complex circumstances that child protective investigators are encountering. We will examine the characteristics and behavior of abusing/neglectful parents and the use of the tool to make open/close decisions. This revalidation will be completed by June 2004. This should allow time for any changes to policy or practice as a result of revalidation to be included in our Program Improvement Plan.

Additionally we will review the cases opened to the Department versus referred to the community to determine if there is a relationship between those avenues and our re-maltreatment data. Following the revalidation we will institute a retraining effort for staff in the use of that important tool and determine if additional changes need to be incorporated into our PIP to enhance child safety.

4. **Children Entering Foster Care Based on Child Abuse and/or Neglect (CA/N) Report (Safety Data Element IV).** Identify and discuss issues affecting the provision of home-based services to protect children from maltreatment and whether or not there is a relationship between this data element and other issues in the State, such as availability of services to protect children, repeat maltreatment, or changes in the foster care population.

At any given time, the Department, through multiple programs, provides services to over 11,000 children and their families. The number of children and families receiving services changes on any given day. For the purpose of the data profile we are using point in time figures for March 31, 2003. As a result, these figures may not resemble numbers or percentages seen elsewhere in the report. Estimates of the children/families served by community agencies to prevent abuse, neglect and/or placement is based on the capacity purchased for such services and approximates 2,100 at that point in time.

When cases are referred to Intake as the result of indicated child protective investigations or voluntary requests for services, families are frequently referred to home-based support services to address issues such as mental health, parenting and family relationships. In those instances where agencies are able to provide services to address the needs of each family member individually, while using a team approach to assess and address the impact of those issues upon other family members, there appears to be a high level of success. Critical to the effectiveness of this approach is the ability to access services through the same agency, immediately upon completion of an investigation. When delays arise as the result of waiting lists, situations tend to escalate. When services are not provided to all members of the family at the same time, or when different service providers are providing different services to each family member, this approach may hinder the ability for the provider to evaluate the family functioning as a whole and identify the impact of one family member's behavior upon the others. It also makes it more difficult to convey to family members the consequences of individual actions upon the dynamics of the whole family. Comprehensive home-based service providers also relieve many families of the burdens caused by lack of reliable transportation and child care. It also should be noted that these services should be accessible without DCYF involvement.

The effectiveness of our use of prevention and intervention services is now just beginning to be measured. Through our work with Yale University and the Data Analytic Center, we have developed and begun tracking outcome measures for contracted programs. The information being collected currently represents aggregate measures reporting on percentages of children identified as needing particular services and whether the needs are being met. The data do not provide child or family specific information. As already referenced, we do not have a Quality Assurance function within the agency at this time to measure outcomes that are child or family specific. And, while some of the prevention programs have been evaluated and are described elsewhere in the assessment, not all have been nor do they meet all of the needs that are identified for the children and families. We have detailed elsewhere the gaps in services -- needs that could prevent placement and/or assist us in reunifying sooner with intensive aftercare

services. Our most pressing need would be for home-based intensive services to prevent placement or to ensure effective reunification.

There were 2,478 youth receiving adoption subsidy on March 31, 2003, some of whom may also have been receiving social services and/or may also have been open to the Department for some of those services. There were 743 victims of abuse and neglect during that month and there were approximately 5,825 children open to ongoing services from the Department in home or in care. Of those, 3,124 (54%) were receiving service in their own homes with 2,701 (46%) children in care. Of those receiving ongoing services and/or those receiving adoption subsidy, approximately 43.5% were female with 56.5% male. Approximately 20% were between the ages of birth and 5 years old, 27% aged 6-11 and 53% aged 12 and older which reflects the increased age of children in the State's population overall, and the makeup of our agency which serves older youth through mental health and juvenile justice programs in addition to child welfare children and families. Since the median length of stay in foster care has remained steady we can only suggest that the older youth are coming into care at an increased rate.

The number of children entering the foster care system as a result of a child protective investigation has remained steady over the past number of years between 23.5% and 25%. A uniform child safety assessment tool is used to determine the necessity for placement versus an in-home safety plan. Although this tool appears not to have altered the number of children entering care it is believed that it has assisted us in determining the appropriate children needing to enter care based on specific safety factors.

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5. **Child Fatalities (Safety Data Element V).** Identify and discuss child protection issues affecting child deaths due to maltreatment in the State and how the State is addressing the issues.

In 1998, the Department developed a Child Death and Injury Review Team in partnership with the Hasbro Child Safe Clinic at Rhode Island Hospital and the State Medical Examiner's office. This team is a multi-disciplinary body comprised of representatives from DCYF, the Medical Examiner, law enforcement, hospital medical personnel, representatives of the Attorney General's Office, and the Office of the Child Advocate. Thankfully, there are not many child deaths as a result of abuse and/or neglect in a given year, but in a nine year period from 1993 to 2002, there were 34 children who died as a result of injuries due to abuse by a parent or caretaker. Any time a child dies it is a tragic occurrence. When there is a child death in which DCYF is involved, the Office of the Child Advocate is notified. The Medical Examiner performs an autopsy and releases the finding on the manner of death to the Department. The Department takes appropriate action as indicated by the Medical Examiner's report.

The Child Death and Injury Review Team assists DCYF in making determinations on cases where the evidence is ambiguous as to whether an injury to a child was intentional or caused by accident. Based on this multi-disciplinary assessment and examination of the evidence, the Department is better positioned in determining what action is necessary for the child(ren)'s

protection. The Team also looks at the larger picture of child deaths in Rhode Island to identify trends, particularly situations where there are preventable deaths, such as swimming pool drowning, fire hazards, etc. The Team focuses on ways to inform public policy as to situations that could or should be addressed to prevent injury or death to children of all ages.

6. **Recurrence of Maltreatment (Safety Data Element VI).** Discuss whether or not the State's recurrence of maltreatment conforms to the national standard for this indicator, the extent to which the State's rate of recurrence of child maltreatment is due to the same general circumstances or same perpetrator, and how the State is addressing repeat maltreatment.

While the data on repeat maltreatment continues to show a significant decline, in 2000 (12.4%) while in 2002 (10.2%), partially due to concentrated data clean up efforts, we are not satisfied that we understand the reasons for the re-maltreatment or the decline in those numbers. We are working with our Data Analytic Center (DAC) staff to address this issue and have committed IV-B funds to hire contracted staff to do a case analysis on a randomly selected sample of children who were the subjects of subsequent reports. The case analysis is focused on a random sample of 30 children who meet the federal criteria for re-maltreatment and 30 who do not. We anticipate the analysis to be completed before the end of this year, but preliminary results of our repeat maltreatment analysis seem to support our sense that we are investigating some families multiple times before achieving any successful conclusion.

We find the highest percentage of numbers occur in the ages of 0-5 and 11-15 and have pulled our sample from those age groups. We will be looking at the recurrence of the same type of maltreatment, the perpetrator data, the services offered and completed, whether the family was open to the Department or a community agency, etc. The Data Analytic Center will then apply any trends detected to the aggregate population. In so doing, we hope this analysis will lead us to identify changes that will bring about positive results in our PIP.

7. **Incidence of Child Abuse and/or Neglect in Foster Care (Safety Data Element VI).** Discuss whether or not the State's incidence of child maltreatment by the foster care provider conforms to the national standard for this indicator. Discuss the ways in which the State is addressing this issue and whether or not there is a need for additional measures to ensure the safety of children who are in foster care or preadoptive placements.

In FY 2002, 156 – 1.10% of children in foster care experienced maltreatment according the Safety Profile compared to 2.6% in 1998. We remain concerned about this issue in spite of the

significant decline. We studied the cases of abuse/neglect from the year 2001 and found that about half of them occurred in family homes and half in group care. A number of the group care incidents appeared to be more like licensing issues, i.e. staffing etc., than actual harm to a child. We have also begun a more in depth case analysis of all of the 38 cases reported during 2002 and a random sample of 38 who were not abused in care. The results will be analyzed by our Data Analytic Center when completed and we hope to have the results by the end of the year. When the results are completed we will either include them in the Statewide Assessment or write an addendum to the Assessment prior to our onsite review.

Allegations of abuse/neglect in foster homes are handled by our Child Protective Investigators and upon completion are referred to our Licensing Administrator for follow-up action. Licensing staff usually have a family meeting which can result in a revocation of their license, a requirement of training, a reduction in the number of children in the home or age of children or type. No statistics are currently kept on those actions.

Rhode Island holds foster care staff to a standard which is higher than that for biological parents. Any physical punishment is considered abuse/neglect. While we continue to be dedicated to these standards of care for our children we must also dedicate our resources to improve the identification, reporting and response to abuse and neglect while we redefine licensing issues with necessary support from our licensing staff. We are also currently working with National Resource Center on Child Maltreatment on extending the safety assessment throughout the life of a case. Concurrently we have begun discussions about the development of a safety assessment for foster and adoptive parents.

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8. **Other Safety Issues.** Discuss any other issues of concern, not covered above or in the data profiles, that affect the safety outcomes for children and families served by the agency.

The Department recognized its need to address child safety throughout the life of a case before and during our pilot CFSR of 2000. We have been receiving technical assistance from the National Resource Center on Child Maltreatment to address this issue. We have used the technical assistance to review and address our initial screening of allegations and resulting investigations. Much weight was put on the findings of the Resource Center. A new administrative staff and new initiatives are underway to enhance the investigative skills and performance of our Child Protective Services. More recently and given the state's performance on the national standards that deal with child safety, i.e. re-maltreatment and abuse/neglect in foster care, we have begun focusing on a more comprehensive approach to safety.

Our system is designed to respond quickly to allegations of abuse and neglect and to determine whether the allegations can be substantiated. Our ongoing staff in Family Service Units have had little recent training and focus on the assessment of safety. We are working with staff from various divisions and functions of the Department to clarify our approach to child safety and to

develop clearer practice guidelines. We are looking at having the short-term investigative staff develop a Protective Plan for short term safety and move cases with a Protective Plan to our Family Service Unit staff to quickly develop the necessary additional information for an ongoing safety plan.

A new universal family assessment process, training and form are in development which will be used regardless of the reason for case opening by all staff. The information obtained, with the assistance of the involved family, will additionally enhance our decision making regarding safety assessment throughout the life of a case. Our present technical assistance is providing supervisors the safety training and support necessary to help their staff engage the client so that sufficient information is gained for decision making.

The assessment of safety will be formally addressed at key points throughout the life of a case and ultimately for each child placed in a foster home. Concurrently a revalidation of our Risk Assessment tool is now under way by the National Council on Crime and Delinquency. With the results of that revalidation we can then look at our approach to risk and safety to ensure the appropriate distinctions are being made and that cases are opened to the Department that most need the attention of the State agency.

While we have many families opened to us voluntarily even following an indication of abuse and neglect, the Department is looking at the revalidation of risk and our expanded approach to safety to inform decision-making about which cases to service, and which cases to refer to specialized community agencies.

In an effort to increase staff proficiency in conducting investigations as well as screening cases through Intake, Child Protective Services (CPS) has developed a number of trainings and is in the process of reviewing and revising some of its documents and procedures. Of particular note, in May of 2003 investigators and intake workers participated in a three (3) day Basic Forensic Interview Training which provided principles/skills for conducting interviews with adult witnesses, alleged perpetrators and collateral contacts. The training was followed by a 3 day Advanced Interrogation/interview Skills training which focuses on expansion and implementation of the interview tools and principles addressed in the class. That training will be followed by basic and advanced Child Forensic Interview training. These and all trainings have been developed to be consistent with our Family Centered Practice initiative.

Our review of risk and safety assessments will incorporate our initial safety plan into the investigative summary to illustrate the allegations, information gathered, investigative conclusions and safety plan. All documents will be reviewed for flow and consistency and where necessary will be reformatted. Lastly, a group of CPS and Family Service (FS) supervisors meet monthly to improve communication, exchange ideas and information so as to ensure a smooth transfer for families from division to division. The group is currently developing a Screen Out category for Hot Line reports, referenced earlier at the beginning of this section. This category would involve reports that do not meet the criteria for investigations (called Early Warnings) and will include reports which involve families who are active with Family Services and involve ongoing casework issues. If the case is open to a Family Service Unit, the worker is

notified and required to document acknowledgement of the notice and/or any actions taken in response.

The Department currently identifies allegations that do not meet criteria for investigations as "Early Warnings." A definition of "Screen Out" is being developed to replace early warnings, and this definition will reflect the following language:

> "Screen Out -- A report that contains a concern about the well-being of a child but does not meet the criteria for an investigation. If a call is accepted as a screen out and the call involves an active case or active licensed placement provider/day care home, then the primary worker assigned to the family/service provider will review the information and respond accordingly. If several screen out reports are made which involve the same family or provider, then the information is reviewed and an investigation may be generated."

B.   Permanency

Outcome P1:   Children have permanency and stability in their living situations.
Outcome P2:   The continuity of family relationships and connections is preserved for children.

Based on examination of the foster care data in the two foster care profiles in section III, and the State Child and Family Services Plan (State IV-B plan), please respond to the following questions.

1. **Trends in Permanency Data.** Have there been notable changes in the individual data elements in the two permanency data profiles in section III over the past 3 years in the State? Identify and discuss any factors affecting the changes noted and the effects on permanency for children in foster care in the State.

The number of children entering care due to abuse/neglect in the Safety Profile is consistently in the 700-800's while admissions during the year in the Permanency Profile are consistently around 1400 -1500. The difference reflects the admissions of our juvenile justice, mental health, developmentally delayed, court referred and voluntary placements. As stated earlier, approximately 38.5% of children are open to the Department because of abuse/neglect, while 28% are open to Juvenile Justice and 33.5% are open because of "Other."

The discrepancy between the number of children in placement on the last day of the year and the first day of the next year has resulted in changes being made to our "transaction data" to correct

the problem. The correction has been made, but a re-submission of our AFCARS is not possible because of staffing levels.

Placement Settings
The Data Profile represents that Rhode Island has a large population of youth in group home settings, and we believe a reason for our higher use of group home settings is the number and type of our population which consists of juvenile justice, wayward/disobedient and mental health populations. Group home settings are often an appropriate placement for these youth because of their intense needs and/or behaviors. The number of young children in shelter and/or group home settings has remained fairly constant over the years. There have been no additional shelter or group home beds developed for young children as openings occur somewhat consistently.

Capacity Development
Our most recent capacity building activities have been directed toward increasing the number of appropriate higher intensity treatment settings in-state in an effort to bring placements closer to the child's community. We reduced the number of distant out-of-state placements between July of 2001 and September 2003 from 70 to 33 (53%) and reduced nearby Massachusetts residential care from 126 to 66 (48%), while we increased our specialized foster care placements from 46 to 96 (109%) and increased our in-state residential placements from 104 to 115 (11%.)

We further have launched a concerted effort to recruit 100 foster beds for our adolescent population to reduce our use of night-to-night placements. Half of those foster beds will be recruited and supported by community agencies and half by DCYF. We expect the success of these efforts will have a positive impact on our use of family settings versus group home and institutional settings**.** In 2002 80% of youth in shelter and residential treatment programs were between the ages of 12 – 18.

Relative/Non-Relative Foster Care
We were surprised to see such a low percent of our foster placements with relatives. We have combined the number of children with fictive kin, which are child specific placements, with the number of children living with relatives. As a result, the number and percentage rises to 612 (52.6%) in relative/fictive kin, and 551 (47.4%) of non-relative placements which is more in line with the efforts and perceptions of our staff. Doing this we can better communicate in our Statewide Assessment the number and percentage of children who have been placed within an existing support system versus with strangers.

Permanency Goals
We are missing between 9 and 10% of the data for "Permanency Goals for Children in Care". We have recently come into compliance with our Juvenile Justice population by requiring a case plan versus the service plan they had been using. The new case plan has been entered into RICHIST and will positively affect the missing data.   We always have a period with new cases where a case plan goal is in development and so there will always be missing case plan goals. We also have open cases, i.e., Interstate Compact on the Placement of Children (ICPC), Domestic Relations studies, subsidized adoptions, etc., that do not require a case plan. We occasionally have a family open to the Department in Intake when they have voluntarily agreed to participate in community services. While those community services are working with the

family no ongoing caseworker is assigned and no case plan is developed because the treatment goals and services are being provided in the community. On occasion those families are open to us for 6 months but our Intake staff does not develop a case plan. The Department needs to address that issue in its Program Improvement Plan (PIP) so that those rare cases will have a monitoring case plan developed as required. Lastly, we have youth at the Rhode Island Training School with no case plans and no case plan is developed if they are placed in a temporary community placement (TCP). We are working with our federal representatives to clarify a number of juvenile justice issues which will result in either explaining our lack of case plans and goals or give us a direction for compliance that will be written into our PIP.

We have between 12 and 14% of our youth with a goal of emancipation. Since we serve a population of juvenile justice, wayward/disobedient and mental health youth as well as child welfare youth, our percentage of older youth in care is likely to be higher than other states. Our percentage of youth in care over the age of 12 is 53% including 98% of the Juvenile Justice population; 24% of the Child Welfare population and 54% of the "Other" category, which includes youth referred from the Teen Drug and Truancy Courts or due to mental health service needs, developmental disabilities, wayward/disobedient, ICPCs, Court ordered domestic home studies, etc. For many of those youth, it may be appropriate to have independent living as a realistic goal.

Yale – Performance Measures summary of findings for FY 2002
Overall, 7,050 children were served in the 93 DCYF-contracted programs during FY02. Of the eight program types, CES served the largest proportion of children (one-third). The town of origin for most children served by programs was in the Northern region of the state. Children ranged in age from birth to over 18 years, with a higher number of older children served in out-of-home (residential and shelter) programs. Children served in out-of-home placements also tended to be more troubled when they entered programs and care from more troubled family backgrounds.

Across programs, a high proportion of children were admitted showing signs of anger and aggression, behavioral problems, family violence or stress, beyond parental control, and problems in school. Residential providers reported the highest prevalence of a wide range of difficulties. Families also presented with a range of problems. Providers reported that the majority of children in need of mental health services received them, and that services were adequate to meet the need in most children. The proportion of unmet service needs was highest in CES, Early Start, Family Preservation, and Shelter programs. A lack of adherence/compliance to mental health service recommendations among parents and/or children was cited as the most common barrier to receiving services.

Most children were discharged because their program goals were accomplished. This was most true in family preservation, outreach and tracking, and youth diversionary programs, where more than one-half of children discharged had met program goals. Nearly one-fifth of children across programs had unplanned discharges. While the outcome measures did not address why there were unplanned discharges, they mostly occurred in shelter placements.

Nearly two-thirds of all the children discharged went home with a parent, guardian, or relative. When discharge dispositions were classified as more or less restrictive/intensive (as compared to the program from which they were being discharged), about three-quarters overall went to less restrictive/intensive dispositions.

Staff working in contracted programs were predominantly white, as were children served. In general, staff diversity matched that of children served. Overall, few staff spoke languages other than English, but staff language abilities generally matched children's language. The largest gap on this indicator was in the Early Start Program, where a higher proportion of children than staff spoke Hmong and Khmer.

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2. **Foster Care Population Flow (Point-in-Time Data Element I & Cohort Data Element I).** Identify and discuss any issues raised by the data regarding the composition of the State's foster care population, rates of admissions and discharges, and changes in this area. Discuss the State's ability to ensure that the children who enter foster care in the State are only those children whose needs for protection and care cannot be met in their own homes.

Population of Children in Foster Care

While there is the perception that Rhode Island's rate of entry into foster care is among the highest in the nation, these data do not take into account that DCYF is a combined child protective, children's mental health, and juvenile justice agency. While entries into care have remained relatively stable with approximately 700 due to abuse and neglect, twice that number of children enter care because of juvenile justice, mental health and other. For children entering care due to abuse and neglect, we believe the safety assessment currently used during investigations of abuse/neglect helps us to screen and to appropriately determine if a child is in need of our-of-home care. As already referenced, we are working with the National Resource Center on Child Maltreatment to implement a safety assessment throughout the life of a case ensuring that the children remaining in care are there because of a need for protection and care not available in their own homes.

Rhode Island serves children and families who become known to us through our Juvenile Corrections Division which includes the RITS and Juvenile Probation (because of a criminal petition), through our Child Welfare and Mental Health Divisions because of abuse/neglect, mental health, developmental delays, wayward/disobedient petition (filed by the parents, schools, etc.) because of behavior related to disobedience, drug and alcohol use, truancy, ICPC, Voluntary requests for services and Court referrals, i.e., Court ordered domestic home studies, etc.

Notable Changes in the Foster Care Population and Possible Contributing Factors

As has been documented extensively, child welfare agencies and children's mental health agencies are seeing a greater level of mental health disturbance in younger and younger children.

The level of disturbance in some instances requires out-of-home placements for purposes of mental health treatment. For example, during fiscal year 2002 there were 261 children/youth known to DCYF who were admitted for treatment in psychiatric hospitals. The total number of state funded children/youth admitted for psychiatric hospital care in just one of the hospitals was 401. Of those, 19 were between the ages of 3 and 5 years old, 60 were between the ages of 6 to 8 years old, 133 between the ages of 9 and 12 years old and 189 were aged 13 and over. Total admissions to our primarily adult psychiatric hospital between July and September of 2002 included 1 four year old, 7 between the ages of 6 and 8 years old and 24 between the ages of 9 and 12 years old with 55 being 13 or older. We believe also that these numbers reflect an increase of placements at the upper end of the placement scale which is reflected in a dramatic spending increase and which suggests unmet mental health needs.

In addition, we believe that the numbers reflect an increase in placements for juvenile justice youth presenting with conduct and behavior which precludes their remaining at home or in their community. This also reflects a growing rate of violence among adolescents, which further drives the placement system.

Statutory Changes to Address Juvenile Justice - Wayward/Disobedient Petitions
During the 2001 legislative session, the provisions of R.I.G.L. 14-1-11 were amended by the legislature and signed into law by the Governor. This change (Article 23) requires proof that an assessment and treatment plan have been unsuccessful in ameliorating family issues prior to the filing of a wayward/disobedient petition. When a parent or guardian wishes to file a petition alleging that a child in their care is wayward by virtue of disobedient behavior, they contact the local police department in the city/town in which they reside. The local police department shall review the matter and instruct the parent to go to the local agency approved by the DCYF for an initial screening/assessment.

The agency, upon meeting with the family and child, shall determine if there have been any prior interventions, as well as conduct a current assessment of the family problems and develop a plan to assist in improving the family's functioning. If a family has engaged in recent service delivery without success and the situation remains unresolved, the agency may document the prior service delivery and refer the matter back to the police department for possible presentation to Family Court. Otherwise the agency shall engage the family in a course of treatment/intervention or refer them to a more appropriate agency.

Should the above interventions be successful, the family would not pursue the matter further with the police. If however, after the agency has made sufficient contact to determine that the family issues would benefit from court involvement and/or the child is unresponsive to the service delivery, the agency may support the family's decision to pursue court action.

During 2003 the department arranged with its network of community provider's to implement Article 23. By the end of 2003 every city and town in Rhode Island had an assigned agency to provide the assessment and treatment planning for those affected families. The Department used its existing contracted youth diversion program providers, some of its outreach and tracking contracted providers, a Title IV-B funded juvenile justice program and one agency that agreed to use its community block grant monies to provide services.

Since the implementation of this initiative, there has been a significant decline in the number of wayward/disobedient petitions filed with Rhode Island Family Court. During the first four (4) months of 2003 there was a 57% decline in the number of such petitions filed compared to the same period in 2002. We have received positive responses to this from Juvenile Officers in the various police departments. During the 2003 legislative session, the department was able to secure an additional $300,000 to assist in implementing this program.

The results so far of implementing Article 23 are having a positive impact on the families using this service, as well as our caseload numbers, our placements for youth, etc. We look forward to the long term effects of this program and anticipate that the services being provided to families will ultimately reduce the number of referrals from Family Court to DCYF placements.

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3. **Placement Types for Children in Foster Care (Point-in-Time Data Element II & Cohort Data Element II).** How well is the State able to ensure that children are placed in the types of placements that are the most family-like and most appropriate for their individual needs, both at the time of initial entry into foster care and throughout their stay in foster care?

State's Capacity to Provide Placements Most Appropriate for Children's Individual Needs
Department Policy, numbered 900.0025, revised in 2001 clearly speaks to safety, permanency and well-being as the desired outcomes of our work with children and families. The Department maintains a child in his/her own home whenever possible; however, when placement is necessary it is the policy of the Department to provide the child with an out of home placement which is least disruptive to the child, etc. Therefore, the Department gives utmost consideration to a relative or "kinship" placement for the child prior to seeking a non-relative placement. The data profile states that 21.9% of our children are placed with relatives but with our additional use of child specific, kinship placements this percentage increases to 52.6% of children.

Point in time data as of January 8, 2004 shows that 493 children were with blood relatives, 49 were with fictive kin and 471 were with non-relatives. We also have 140 children/youth in private agency foster homes.

When children cannot be with a relative or kinship provider then the worker requests a placement from our Placement Unit and the worker provides a profile of the child and his/her needs for matching. Depending on the age of the child, behavior, needs, etc. the placement unit first attempts to place a child with their siblings in a foster home. Shelters and group homes are sought when appropriate and/or when a family placement is not available. If a child is placed in a shelter, during the 90 days of that placement the worker and placement unit continue to find a relative, kinship provider and/or other family setting. We know that children placed with

relatives/fictive kin are much more likely to be placed appropriately and experience fewer disruptions in placement (Yale Study).

It is also important to note that the Profile data indicating that only 1.1% of foster children are placed in pre-adoptive homes does not present an accurate picture. Since approximately 80% of all children adopted are adopted by their foster family, the low percentage of pre-adoptive placements does not reflect the much larger number of children for whom termination of parental rights and adoption is a case plan goal.

As in our 2000 CFSR pilot, the number of relative family homes appears lower than we think is actually the case. We did anticipate fewer relative foster care homes because of the tightening of ASFA requirements for relatives and while attempting to bring previously certified relatives to licensing standards we lost an estimated 40 families.

The data provided in the Permanency Profile show that over 52% of children are in family homes (relative, non-relative and pre-adoptive). The Department; however, is not able to assure that children are placed in the types of placements that are the most family like and most appropriate for their individual needs, both at the time of initial entry and throughout their stay, because of a serious lack of foster family homes, resulting in demand for and use of all other types of placements. One of Rhode Island's critical needs is for a sufficient number and type of foster homes so that the first placement in foster care is an appropriate match. We all too often place a child in a less than ideal placement at the time of entry, which later increases the likelihood that a subsequent placement will need to be made.

Range of Placements Needed and Placement Resources Available

As already referenced, we currently have a recruitment effort under way to add 100 foster homes which will hopefully assist us to attract families who can safely care for the challenging older youth we need to place. The changing pattern of family life has seriously affected our foster family system of care as it has nationally. Even those families whom we are able to recruit oftentimes require daycare for children placed with them, as they are most likely to be two working parent families. We have attempted to address this problem not only through expanded recruitment but also through an increase in the number of specialized therapeutic foster care slots. Since 2000 those specialized slots have increased 109%.

We are committed to identifying and examining the numbers and especially the types of children placed in group homes. With Rhode Island having juvenile justice and mental health youth in placement it may be that it is appropriate for significant numbers of those populations to be in group settings which can meet their individual treatment needs. The institutional data suggests that we must also examine that data for understanding and cleanup since the numbers appear too low even for youth in psychiatric hospitals.

Lastly, the percentage of Rhode Island youth population and our population in placements of those 11 or older continues to rise from 55% in 1998, 57% in 1999, 60% in 2000 to 61.5% in 2001 suggesting again that the juvenile justice and mental health populations are rising in proportion to those in care due to abuse/neglect. That further suggests that placements and

programming needs have to be identified which would meet the specific needs of each of those populations.

Managed Networks

As earlier referenced, the Department has begun to develop a managed network approach for continuity of care within a continuum from residential through to home-based services and support. The initial Network, in April 2000, was designed to operate statewide. It was comprised of three child welfare agencies and the state's largest community mental health center forming a partnership to provide placements and wrap-around services to 63 youth and families referred. The array of services include staff-secure placements, group homes, staffed apartments, foster care, independent living and home-based services. Core principles include serving youth referred under a 'no reject/no eject' model, least restrictive level of care, ensuring community partnership, central clinical/case manager to follow a youth, greater flexibility in service provision but greater accountability through pre-determined outcome measures. To date the Network has provided DCFY with reports demonstrating this model can accept and manage all youth referred, can successfully move youth through less restrictive levels with a significant percentage achieving reunification and decrease lengths of stay in residential programs. Outcomes to date = 68% discharged to reunification, adoption, or ILP. One hundred percent (100 %) enrolled in school or vocational program, received clinical services, 80% met all of their service plan goals, 90% demonstrated improved life skills and 11% experienced a psychiatric hospitalization (decrease from 27% over the prior year).

A second, regionally-based, Network for the Providence Region became operational in July 2003. Today, the managed networks, combined, are providing a full range of services through continuity of care for 155 bed/youth.

Permanency, Stability and Resource Development

Out-of State, Distant Placements -- The Department contracted for external utilization review beginning in September, 2000. The contract was awarded to a partnership of a child welfare agency with significant managed care experience and a mental health center. The partnership, called Placement Solutions, began systematic reviews of all children in placement, reviewing services and facilitating transitions to less restrictive care. Initially they focused on youth placed furthest away from their home communities. The program then began a concentrated effort to review youth placed in neighboring states, as well as youth placed in state. As a result at the end of September 2003 there are 30 youth in out of state placements down from 73 in 2001; there are 70 youth placed in nearby Massachusetts down from 120 in 2001; there are 122 youth placed in residential treatment in Rhode Island up from 94 in 2001 and 106 youth in Rhode Island specialized foster care up from 39 in 2001. Demonstrating a significant drop in the number of placements further away from their homes and a significant increase in the number of in state treatment beds.

The State reported "night to night" placements as an area needing improvement in it's 2000 CFSR pilot. In the most recent six (6) month period between March of 2003 and October of 2003 the total number of episodes of night to night placements has steadily dropped from a high of 122 episodes involving 29 youth to a low of 6 episodes involving 5 youth on October 1, 2003.

A number of efforts outlined below have been under way to reduce the incidence of night-to-night placements and to eventually eliminate the practice completely.

Target: 100 specialized adolescent foster care beds by end of FY 2004
- vendor selection and certification began in October 2003

Target: Expand adolescent shelter bed capacity by 16 beds by end of FY 2004
- 12 new beds have been opened – 6 for young women – 6 for young men
- 12 additional beds are slated to open by spring 2004

Target: Create a second multi-agency placement network – add 20 slots during FY 2004
- new Providence network opened July 1, 2003 – currently there are 56 beds operating with 14 more anticipated to be opened by January 2004 including 6 staff secure, 7 foster beds and 1 independent living

Target: Expand sub-acute level psychiatric care and capacity – add 16 beds by end of FY 2004.
- 8 bed residential facility opened in August, 2003.
- 10 responses to a Letter of Interest (LOI) which are currently under review with additional beds expected to be operational in January, 2004
- ongoing work with Neighborhood Health Plan of Rhode Island (NHP) to develop an intensive residential treatment facility for three to four month program focused on meeting acute care needs of youth diverted from – or stepping down from psychiatric hospital
- another LOI has been issued seeking a vendor for an 8 bed sub acute residential psychiatric program for Serious Emotionally Disturbed (SED) and Developmentally Disabled youth
- 2 vendors have been identified for the development of a sex offender treatment program at the Rhode Island Training School to be opened by January, 2004

Target: ongoing diversionary program for wayward/disobedient youth (known as Article 23) requiring families to make efforts to receive therapeutic interventions prior to petitioning Family Court.
- 56% reduction in wayward/disobedient petitions since the program began - as of September 26 of this year, 296 wayward/disobedient petitions had been filed compared to 671 in the previous year

Target: continue active partnership with DHS and other State agencies to provide one-stop-shopping for families and children with special needs to obtain assessment and referrals for service.
- to date, 4 centers are open – while still in development in terms of access by DCYF families. Cross CEDARR and DCYF training is taking place to address referrals, accessibility and availability

Target: continue to be highly selective about placing youth in out-of-state placements –
- 98 youth were placed out of state as of October – a reduction of 51% since July, 2001.

> o 28 were placed in distant states
> o 70 being placed in nearby Massachusetts

Target: continue to work with Rhode Island Family Court's Truancy Court to develop an agreement regarding *appropriate* sanctions and protocols for youth in order to avoid having youth placed in DCYF custody as a "sanction" by the Court, which then creates a "night to night" placement circumstance due to insufficient placement resources.

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4. **Permanency Goals for Children in Foster Care (Point-in-Time Data Elements III & VIII and Cohort Data Elements III & V).** Discuss the extent to which children in care are moving safely into permanent living arrangements on a timely basis and issues affecting the safe, timely achievement of permanency for children in the State.

The statistics provided in the Permanency Profile for Data Element #3 – Permanency Goals for children in Care in 2000 indicated that 580 cases were missing a permanency goal while in 2002 that number is 253 as a result of retraining and data cleanup. The Department's SACWIS system has continuously been improved since its implementation, and this attention to quality improvement continues in regard to the way a case plan is entered. Our most recent figures report that only 10.5% of all cases open to Family Services do not have a reported case plan. Another explanation for the data inaccuracy is a matter of interpretation where in juvenile probation cases there was a *Service Plan* versus a Case Plan, and as a result, goal information was not captured in RICHIST. Again, this issue has been corrected and Juvenile Corrections staff are now completing a Case Plan that is captured in RICHIST. Lastly, since this data are generated at a point-in-time and case plan completion is not required for 30 to 60 days following assignment to a worker, a goal may be reported to AFCARS as missing during that period.

The Rhode Island Data Analytic Center conducted three studies related to permanency of Rhode Island children in out of home care. The analysis was completed in March of 2003. The studies looked at:

- Rates of Exit to Permanency for Children in Substitute Care,
- Predictors of Exits to Permanency for Children in Substitute Care, and
- Length of Placement in Substitute Care Settings.

Data for Rates of Exit to Permanency were drawn from the RICHIST system and obtained for all substitute care episodes for a cohort of children who entered the child welfare system between January 1, 1998 and December 31, 2001 and cases were followed over a one-year period to identify exits to permanency (i.e. reunification, adoption, or placement in a legal guardianship). Child characteristics (i.e. age, gender, race), as well as characteristics of the episode itself (i.e. year episode began, number of prior removals, number of placements during episode) were examined to identify potential influences on rates of exit to permanency for children in substitute

care within a one year period. Cox Hazard Regression was used to examine the effects of child and episode characteristics on rates of exit to permanency over the first 12 months in care. In conclusion, the median length of time to permanency is greater than 12 months, with 44% of children in the system exiting to permanency as of 12 months in care. The results show that child and episode characteristics have a significant impact on rates of exit to permanency. Children demonstrated faster rates of exit to permanency if they were between the ages of 11 and 15, they were girls, they were of Hispanic ethnicity, they entered the system in 2000 or 2001. Children demonstrated slower rates of exit to permanency if they were below the age of 11, particularly if they were under 1 year of age, they were boys, they were African American, they entered the system in 1998 or 1999. We believe the exits to permanency for those entering in 2000 and 2001 are driven by the policy and practice impact of ASFA.

Data for Predictors of Exits to Permanency for children in substitute care were drawn from RICHIST and were obtained for all substitute care episodes for a cohort of children who entered the child welfare system January 1, 1998 to December 31, 1999. Children were followed for three years to examine the overall proportion of children who exited to permanency over a three year period. Rates of exit were then examined for the following periods: 6 months or less, 6-12 months, 12-24 months, and 24-36 months. In addition a second cohort of children who entered the system between January 1, 1998 and December 31, 2001 was drawn in order to identify indicators that predicted exits to permanency after 1 year. This latter sample was selected to determine whether there had been any marked changes in exits to permanency over time, and to identify whether there were patterns in exits to permanency based on child or episode characteristics. Indicators examined were child age (under 1, 1-5, 6-10, 11-15, over 16), gender, rate/ethnicity (white, African American, Hispanic, Other), number of previous removals from the home.

Two types of analysis were presented – results which indicate the percentage of children who exit to permanency over a 3 year period and findings which identify child and episode characteristics that predict permanency one year following removal. The results indicate that almost one-half of children removed from the home exit to permanency within six months and almost two-thirds within 1 year. Of those children who exit the system to a permanent placement, the overwhelming majority are reunified with their family. The results also showed that there are several clear predictors of exit to permanency within a 1 year period. Children were more likely to exit to permanency if their removal was court ordered or they were removed on a 48/72 hour hold, they were initially placed in non-relative foster care, emergency placement, or psychiatric hospitalization or they entered the system in 2000, or 2001. Children were less likely to exit to permanency if they were under 1 year old at the time of the removal, they were African American, they had multiple transitional placements for this particular episode, or they were removed because of neglect, physical abuse, or sexual abuse.

We believe we are appropriately moving children who have been abused and neglected into safe, permanent living arrangements. According to our data profile, our median length of stay in foster care is 14 months and 66.2% of children in care are reunified within 12 months. Our percentage of children with relatives and fictive kin add up to 54%, our adoptions are by foster parents 80%of the time. With a QA system we will be looking to measure this in real time and track the predictors of safe and timely achievement of permanency. We also have many older youth in

care because of criminal, disobedient behaviors and mental illness that are court ordered or sentenced to residential treatment facilities for a period of at least one year. At the same time, the length of stay at the RITS has increased from 9 to 10 months and the median age has gone from 16.7 to 17 years of age.

We have made and are continuing to make major changes to our practice with respect to youth on probation and youth entering the Rhode Island Training School (RITS) from a placement or exiting the RITS to a placement. We've just reached agreement with Family Court and our Federal Regional Office on the language appropriate to permanency hearings for juvenile justice youth, and permanency hearings are expected to begin by within two months. Case plans for probation youth in out of home care are now identical to those for youth in child welfare. Training has been given and case plans are now being developed for those youth. Further family centered practice changes for youth open to Juvenile Justice who are serviced in home will be seen in our PIP.

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5. **Achievement of Reunification (Point-in-Time Data Element IX).** Discuss whether the State's data regarding achievement of reunification within 12 months from the time of the latest removal from home conform with the national standards for this indicator. Identify and discuss issues affecting conformity and how the State is addressing the issues.

In Rhode Island, the number of children entering care due to abuse/neglect has remained consistent over the last several years. In 2002, according to the State's data profile, the number of children/youth entering care due to abuse/neglect was 854. The total number of admissions into care in 2002 was 1,582, of which 728 entered due to juvenile justice, mental health needs, or "other." Other refers to children and youth who become known to the Department because requests for voluntary services, court referrals, wayward/disobedient petitions filed by the parents or schools because of behavior, truancy, Interstate Compact for Placement of Children (ICPC), etc.

Reunification with a child's primary caretakers is the primary goal for a child or youth in the custody of the Department. Youngsters may be placed in substitute care based upon an abuse/neglect/dependency petition, a voluntary agreement, a wayward/disobedient petition or a delinquency petition. Once a child is removed from home, the Department is obligated in accordance with state and federal law to work with the child's family towards reunification. The child is assigned a primary worker who is responsible to develop a family assessment and case plan in collaboration with the family that focuses on the reasons why the child entered care and what needs to be done to successfully reunify the family. In all cases where there is legal involvement, the case plan is shared with the Family Court and is subject to Family Court approval. The family is made aware of permanency planning timeframes and the need to work expeditiously towards reunification.

In the five years that we have been tracking data through the RICHIST (SACWIS) system, the Department has seen a slight fluctuating pattern in the percentage of children reunified with their families, but the trend overall has been steady.

Year	Children Exiting Foster Care	Percentage of Children Exiting to Reunification	Children Reunified within 12 Months from Latest Removal from Home
1998	915	59.2% - 542	n/a
1999	1,018	62.7% - 638	n/a
2000	1,348	55.4% - 747	506
2001	1,227	66.4% - 815	581
2002	1,378	67.8% - 935	635

According to the Permanency Profile, of all children who exited care in FY 2002, 83% achieved a permanent placement through reunification, adoption, guardianship, or living with a relative mostly in less than 24 months. In addition, of all children who were reunified with their parents or caretakers at the time of discharge from foster care, 66.2% were reunified in less than 12 months from the time of latest removal.

As stated earlier, we have a population of older youth who because of criminal petitions, behavior or illness are court ordered or sentenced to residential treatment facilities or the RITS for a period of at least one year. According to the predictors of reunification done by the Data Analytic Center, older youth 16-20 are less likely to be reunified, youth with 2 or more placements are less likely to reunify, and those who have been abused and neglected. Those more likely to be reunified quickly include girls, Hispanics, those with behavior problems, and those in shelters. The age of the child directly correlates to the likelihood of reunification and we have an older population of youth.

While we are 10% below the National Standard using Point-in-time data, our longitudinal data shows us doing quite a bit better. The issues affecting our lack of timely reunification is an area for further study and examination at the time of our On-Site Review. The additional factor for our State is that since 1998 the percentage of youth in care over the age of 11 has risen each year from 54.7% in 1998, 57.2% in 1999, 59.9% in 2000 and to 61.5% in 2001. This age range suggests that we have more of the older juvenile justice and mental health youth in care. According to our federal data the number of youth in care between 11-15 years of age has increased from 25.8% in 1997 to 33.3% in 2000 with a similar decrease in children aged 1-10 during that same period. Since the number of children entering care due to abuse and neglect has remained fairly consistent over that time we believe that the increase is in our juvenile justice and mental health population of youth. The specialized treatment programs for the complex conduct, behavioral health and diagnosis may well require a year or more of treatment for those issues before a step down program or successful reunification is possible. Our Program Improvement Plan will include tasks to better identify our Child Welfare, Mental Health, Juvenile Justice and Other populations in care and comparison by age. That accomplishment will enable us to enhance our programming by type, age and service needs, etc. so that we can

enhance prevention, intervention and aftercare services that are common and distinct between populations.

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6. **Achievement of Adoption (Point-in-Time Data Element X).** Discuss whether the State's data on children exiting foster care to a finalized adoption within less than 24 months from the latest removal from home conform to the national standard for this indicator. Identify and discuss issues affecting the number of children placed for adoption in the State and how the State is addressing the issues.

Rhode Island is in substantial conformity for children achieving adoption within 24 months of their last entry into care. According to the Permanency Profile 45% of Rhode Island's children are meeting or surpassing that goal. Rhode Island has made major strides in freeing children for adoption and placement for adoption following a change in our state law in l994. This change increased our ability to file for termination of parental rights much sooner and for more children.

Our experience over the last 8 years has shown the following:

Year	1995	1996	1997	1998	1999	2000	2001	2002
# of Adoptions	216	332	221	230	288	292	270	267

Our numbers have also remained high following the Family Court implementing a case mediation process, and as ASFA philosophy was incorporated into practice both in casework planning and the legal system, we were able to move cases more quickly through the system. Our adoption number appeared to peak in 1996, following significant changes in our state law on adoptions and Department practice. Since then the number of children adopted has begun to stabilize.

Early evaluations of our Family Centered Practice initiative show promising results for our ability to move through the adoption process quickly, when working collaboratively with families to reduce the time spent in court and to achieve consensus more readily on placement and permanency decisions. Staff in the Adoption and Foster Care Preparation and Support Unit work closely with Family Service Unit caseworkers, educating and assisting with adoption registration, presentation, and the placement process. Continued support for social workers and pre-adoptive families by Adoption Promotion and Support Staff, as well as mediation and concurrent planning, have enabled us to continue to achieve early permanency for children and to further support new families created through adoption.

Although concurrent planning did not operationalize as planned, it can be seen to be very successful when viewed on a case-by-case basis. Due to the general shortage of placements it

has not been possible to maintain a pool of foster homes that are interested in doing concurrent planning. However, all foster parents are receiving training on concurrent planning and, after being educated on the benefits for the child, most are open to a concurrent approach with the families of the children who are placed in foster care. Eighty percent (80%) of our adoptions are foster parent adoptions and many of these have developed some degree of openness with the birth family through the concurrent planning model. As referenced previously, we have committed Title IV-B dollars to assist in developing an Adoption Certification Program to train private mental health workers in being able to better understand the dynamics of adoption so that they can provide appropriate support for the child(ren) and family toward preventing adoption disruptions or dissolutions.

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7. **Termination of Parental Rights (TPR) (Point-in-Time Data Element VI).** Discuss the extent to which the State complies with the requirement at section 475(5)(E) of the act regarding termination of parental rights for children who have been in foster care 15 of the most recent 22 months, for abandoned infants, and for children whose parents have been convicted of the listed felonies. Identify and discuss the issues that affect timely termination of parental rights, where appropriate, including the use of the exceptions to the TPR provisions.

Our SACWIS system generates a monthly report to Administrators with a listing of all children in care for 15 of the last 22 months. The administrator reviews each case and any compelling reason to not file with the supervisor. A mechanism is in place to cite if the TPR has or will be filed or if a compelling reason has been sought and approved by the Administrator. We believe this has not only brought us into compliance but organizes the review of cases to the benefit of all involved. The resulting in depth reviews afford an opportunity for the supervisor and administrator to plan for and review permanency options for youth in a consistent and timely manner. Using current point in time data, we have reported on 2,699 children who were in care for 15 of the past 22 months, or 12 consecutive months. Of those:
- 593 (22%) had a TPR granted,
- 890 (33%) closed and
- 76 TPR have been filed.

The remaining are active with another goal in place, i.e., placement with relative, are under review and/or TPR is actively being considered.

As indicated earlier, our Department's effectiveness in pursuing termination of parental rights and adoptions precedes the enactment of ASFA. Rhode Island law and practice, combined with mediation efforts at the Family Court, resulted in an increase in timely adoptions. However, barriers to TPR's and adoptions include occasional lengthy extensions for families, judges who require that an adoptive family be identified before TPR, and the lengthy appeal process through our State Supreme Court.

8. **Stability of Foster Care Placements (Point-in-Time Data Elements IV & XI and Cohort Data Element IV).** Using data element XI on the point-in-time permanency profile, discuss whether the percentage of children in the State who have been in foster care less than 12 months and have had more than two placement settings conforms to the national standard for this indicator. Using all three data elements noted above, identify and discuss the reasons for the movement of children in foster care in the State. If there are differences in placement stability for children newly entering the system (cohort data) compared with the total population of children in care (permanency data), identify and discuss those issues.

The Department has been headed in the right direction on this measure for several years. According to the Permanency Profile 82.3% had no more than two placement settings while 81.8% of the cohort group had two or fewer also. In spite of the positive trend, the Department remains concerned with these numbers and in particular with the knowledge that a small number of youth have experienced multiple episodes of night-to-night placement and/or a number of episodes in shelter care before establishing themselves in an appropriate treatment setting. Recently the highest number of night-to-night episodes (March 30, 2003) was 122 which involved only 29 youth. The same number (29) of youth had been involved the previous week with 99 episodes.

We have improved practice because of our use of relative and fictive kin. The Data Analytic Center study shows that relative foster care placements are more stable. Also, we have added more comprehensive services to our shelters and group homes, i.e., clinical services, family work, and increased our private agency therapeutic foster home capacity. The Networks now in place will likely also serve to increase our placement stability over time.

The Department is utilizing a Care Management Team to address the more difficult placement needs and when unsuccessful a youth is referred to our Resource Management Team for more creative options. These two efforts have proved quite successful and are well viewed by the family and provider community who are invited to attend and discuss the placement needs with an eye toward home-based services where possible. The Resource Management Team also serves as the planning function for high-end, treatment specific, i.e. sex offender treatment, and resources with a continued emphasis on home-based or community-based intensive placements. Again, the ability to identify the youth as Child Welfare, Juvenile Justice, and/or Mental Health will assist in more targeted resource options being developed.

9. **Foster Care Re-Entries (Point-in-Time Data Elements V & XII).** Using data element XII, discuss whether the percentage of children who entered foster care during the period under review who had a prior entry into foster care within 12 months of a prior foster care episode conforms to the national standard for this indicator. Using both data elements, discuss the extent of foster care re-entries for all children in the State's placement and care responsibility, the issues affecting re-entries, and how the State is addressing the issues.

Based on the AFCARS comparison data for national child welfare outcome measures, the Department of Children, Youth and Families is able to see how it is performing in relation to nationally established standards for critical child welfare measures. The measure indicated below represents that DCYF is at substantial variance with the national standard for youth re-entering foster care, though some measurable improvement is shown for 2002.

Measure	National Standard	Rhode Island 2000	Rhode Island 2001	Rhode Island 2002
4.2 Children re-entering foster care within 12 months of a previous placement	8.6%	20.80%	20.90%	19.2%

Our performance on this measure is of great concern to the Department. Following recent discussions with the Children's Bureau, our recording and practice regarding reunification will be changing. We have traditionally recorded "reunification" at the time the child/youth returned to the care of the person who was their caretaker at the time of their removal. According to our AFCARS review our practice must change and we must report these children/youth at home as on a "Trial Home Visit" which will require that the children will continue in AFCARS for six months or until our care and custody is relinquished.. This is a major change, the impact of which is not fully known at this time. Further discussions with the Children's Bureau and Regional staff will identify the breadth of these changes. This is likely to increase the time to achieve reunification, but may positively impact our performance on reopening to care within 12 months of reunification.

Another approach to having a better understanding of the factors contributing to our current performance on re-entry to foster care is a longitudinal study being conducted by the Yale University Child Welfare Data Analytic Center. Preliminary information based on an analysis of data from a sampling of children/youth in DCYF care from January 1, 1998 through December 31, 2000 has been useful in providing a profile of the children/youth returning to care, as represented below.

2,814 youth that entered foster care between January 1, 1998 and December 31, 2000 and also discharged from foster care during that period.

- o Gender: 44.8% female, 55.2% male

- o Race/Ethnicity: 60.1% White (non-Hispanic), 19.1% African American,

    15.9% Hispanic, 4.8% "Other"

- o Age at initial removal:
    - under 1   11.7%
    - 1 to 5   15.8%
    - 6 to 10   13.5%
    - 11 to 15   37.6%
    - 16 and over   20.1%

This initial report represented that, overall, approximately 25% of children who exit care return within 12 months. The cohort significantly more likely to re-enter foster care are children/youth between the ages of 11 and 15. This cohort also represents the largest number of children/youth coming into care, 37.6% of the 2,814 children/youth in the sample entering care from 1998 through 2000. Additionally, the Yale analysis takes a more longitudinal view and represents that:

- ▪ Children who initially entered the system through a psychiatric hospitalization or residential DAS (Diagnostic Assessment Service) are significantly more likely (approximately 1.75 times as likely) to re-enter within a 24 month period compared to children who's initial service setting was in relative foster care.

    Wayward/Disobedient and emotionally disturbed youth are ordered by the Family Court into a diagnostic assessment service (DAS), which is a residential facility, for a 2 week assessment and diagnosis. The Court gives the Department custody of these youth while they are in residence at the DAS program, and when they return home those that have been assessed as needing a residential treatment facility wait for an appropriate placement to become available. This sequence of events causes the appearance that the youth entered our care, were reunified, and then re-entered within 12 months; thus negatively impacting the Department's representation on the national standard for this measure. Youth who entered our care from a psychiatric hospitalization with chronic and/or pervasive mental health issues who are sent home with intensive wraparound services often need re-hospitalization for a period of time and again this appears as if a youth were in placement, were reunified and entered care again within a year. In each of these scenarios it is appropriate that we serve these older youth in this way and it should not negatively impact our performance on this national standard.

- ▪ Children who's initial removal involved four or more placement settings are significantly more likely to re-enter care within 24 months (approximately 1.5 times as likely) than those who remained in one placement setting prior to discharge.

- Children with at least one prior removal were slightly less likely (0.8 times as likely) to re-enter following discharge than those who's initial removal was their first.
- Children who discharged from care in 2000 were slightly less likely to re-enter within 24 months (0.8 times as likely) than those who discharged from care in 1998 or 1999.
- There were no gender or race/ethnicity effects observed for children's rate of re-entry after accounting for child and initial removal characteristics.

As already referenced, the Department is working with Yale University to more directly identify a sample of records from this analysis, and conduct a quality assurance review to determine the appropriate strategies for improving this outcome. The analysis of two cohorts in the record sample will examine the re-entry of children from birth to five years old, and children/youth from 11 to 15 years of age. The Department is interested particularly in knowing whether the cohort of older children is representative of youth entering our system through juvenile justice or through the need for children's mental and behavioral health services. Overall, we want to ensure that children/youth leaving care are receiving the necessary and appropriate level of wraparound support in reunification with their biological or adoptive family. The Department also wants to focus on key strategies for improving services that may effectively divert the population of youth who are cycling into the child welfare system, but are not victims of abuse and/or neglect.

The Data Analytic Center is conducting a re-analysis of the longitudinal study including data from years 2001 and 2002. This deeper analysis will be significantly different from previous runs because Yale has incorporated analytic procedures to track the impact of service setting; e.g., foster care with relative homes and non-relative homes, group homes, etc. We expect to have a much better understanding of system performance and child well-being looking at this longer period of data for follow up, especially with the variables for service setting being included.

While we continue to show slow improvement the numbers are so alarming that further review and evaluation is warranted. Again, with the assistance of our Data Analytic Center and flexible IV-B funding, we have been able to commit dollars to do a random case sample of youth who experience re-entry into care. We have targeted re-entry, re-maltreatment and abuse/neglect in foster care for our priority case analysis. The information gained from the case analysis will enable the Data Analytic Center to further apply those trends/theories to the aggregate populations to allow us the benefit of data for decision-making relative to our Program Improvement Plan.

Given the makeup of our youth in placement it is possible that a number of the re-entries are appropriate re-hospitalizations for our youth experiencing serious mental health issues, or may be a youth who was Court ordered to an inpatient Diagnostic Assessment Center (DAS) only to return home to await an appropriate treatment facility, or may be a juvenile offender who was successfully discharged from care only to re-offend and require further residential treatment. We expect an in-depth study of a random sample of these populations will be completed in sufficient time to further verify during our on-site review and in preparation for our PIP. Additionally, the concern over re-entries to care from reunification will be further highlighted by the end of the

year when we have completed our analysis of a sample of cases that re-opened versus cases that did not.

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10. Length of Stay in Foster Care (Point-in-Time Data Element VII & Cohort Data Element VI). Using data element VI in the cohort data profile, discuss how length of stay in foster care for first-time foster care entries in the State compares with the national standard for this indicator (although this indicator is not used to determine substantial conformity). Examining the data on length of stay in both profiles, identify and discuss factors affecting length of stay in foster care and how the State is addressing the issues. If there are differences in the length of stay between children newly entering foster care in the State (cohort data) and the total population of children in care (permanency data), identify and discuss the reasons.

According to the Permanency Profile, the length of stay is 14.0 months and for the cohort group it is 14.3. While we have shown improvement in this area, we do believe that length of stay, given the number of youth over 11 in care and their need for treatment programs that often exceed a year, will be slow to reflect further improvement. As we've referenced previously, the work of Placement Solutions to conduct Utilization Review (UR) on all out-of-state and in-state high-end residential treatment, group home, shelter and soon specialized foster care has assisted the Department in achieving the shortest length of stay possible while focusing on achieving the goals of the youth in completing the program. The numbers they have generated and the effect on length of stay so far has had a very positive effect on our overall length of stay data.

Data for the Length of Placement in Substitute Care Settings was drawn from RICHIST from all substitute care placements beginning between January 1, 1998 and December 31, 2001, with follow-up on December 31, 2002 to provide at least 12 months of data for every placement in the dataset. Demographic data (i.e. gender, race, ethnicity) were examined for the sample of 6,772 children. Slightly more than half (56%) of the sample was male (female 44%). Two-thirds (69%) of those experiencing an episode of substitute care were white, 21% African American, 2% Asian, 1.5% Native American, 1% other and 6% missing/not known.

Across placement setting types, foster care placements account for 37% of all placements and tend to have the longest duration. The median average length of placement in non-relative foster care is much shorter than other foster care placements, reflecting a tendency to remain in placement longer when placed with a relative foster care provider. Emergency placement settings account for 29.3% of all substitute care placements and have a median average length of stay ranging from 1 day to just over 1 week. Residential setting placements account for 27.9% of placements and demonstrate significant variability in median average length of stay; from a low of 5 days for supervised apartment placements to a high of 245 days in high-end residential treatment facilities. Overall median average length of stay appears to have remained relatively stable over time. Looking specifically at foster care settings median average length of stay has been fairly consistent over time. In emergency placement settings, stays have remained

remarkably consistent over time, and stays in residential treatment settings reflects a steady increase in median average length of stay for high-end residential settings. The data for residential treatment – contracted programs reflects a sharp increase from 2000 (33.5 days) to 2001 (161 days).

Further questions are raised by this data which warrant a more detailed case analysis. The difference in length of stay in relative foster homes versus non-relative needs to be examined as to the culture, practice etc. that leads to such differences. The predictor data that 29% of placements are voluntary warrants a look at our practice. Since we service youth with mental health needs that cannot be met in the community setting, we do not require a petition or finding of dependency on the part of the parents. Further study needs to examine if those youth justify a 29% voluntary case status and we must continue to focus on the development of community treatment options. Lastly, children with a history of prior removals were more likely to achieve reunification in less than 12 months than those with no prior removal. Further examination as to policy, practice and underlying causes for those differences needs to occur. The Department will need to establish an ongoing Quality Improvement function to facilitate individual and aggregate case analysis such as these that are necessary to guide practice change and improvement.

Younger youth with mental health issues are often in care for periods of time in hospitals and/or residential treatment facilities that are of a longer duration, and juvenile justice youth are Court ordered or sentenced to residential treatment or the Rhode Island Training School. Our sometimes lengthy waiting lists for Outreach and Tracking may be delaying some of those youth who are ready to return to their families and their community, but an in-home wraparound service is not available. The mix of children/youth in care will need to be identified as we develop our Quality Assurance system to track the length of care given, ASFA mandates, mental health needs, and sentencing requirements.

In conclusion, between our data cleanup efforts and concentrated UR efforts over the last couple of years we have been able to show steady improvement in this area. With continued UR efforts and the tracking and assessment of outcome measures for all contracted programs we anticipate a continued, if somewhat slower, rate of improvement. Overall, the data reveal noticeable differences in the median average length of stay across placement types, as well as some important changes in patterns over time – particularly in residential treatment setting placements. It is important to recognize, however, that length of time in placement settings does not necessarily indicate an increase in overall length of stay in care. Increases in placement lengths could also indicate an increase in placement stability (i.e. fewer placement transitions during episodes of care). Subsequent reports are needed that examine placements within the context of substitute care episodes, as well as total length of stay in substitute care from removal through discharge.

11. **Other Permanency Issues.** Discuss any other issues of concern, not covered above or in the data, that affect the permanency outcomes for children and families served by the agency.

Once again, when resources are available to assist us in clearly defining distinct Child Welfare, Juvenile Justice, Mental Health, and blended populations, the Department will be able to make correlations with the data and program changes to positively effect the performance measures.

C.   Child and Family Well-Being

The following exploratory questions are intended to assist you as you complete the statewide assessment by addressing the child and family well-being outcomes:

Outcome WB1: Families have enhanced capacity to provide for their children's needs.
Outcome WB2: Children receive appropriate services to meet their educational needs.
Outcome WB3: Children receive adequate services to meet their physical and mental health needs.

Based on any data the agency has available, please respond to the following questions.

1. **Frequency of Contact Between Caseworkers and Children and their Families.** Examine any data the State has available about the frequency of contacts between caseworkers and the children and families in their caseloads. Identify and discuss issues that affect the frequency of contacts and how the frequency of contacts affects the outcomes for children and families served by the State.

Changes in Approach
The assessment of family, child and foster home needs has been approached very differently in the past and the frequency of contact between staff and families and youth has looked quite different as well.   The assessment of families and youth in Family Service Units is based on safety, risk and needs for families who became known to DCYF because of abuse and neglect. Other families becoming known to the Department because their child/youth needs mental health services, or on a wayward/disobedient petition because of behavioral issues, have been assessed with the primary child/youth and their family as the focus and not always have the other siblings played a major role in the assessment or provision of services. Youth becoming known through the juvenile justice system have been assessed based on risk of recidivism and service needs primarily of the youth before the Court. The community need for safety and parents' needs were also assessed but secondary to or concurrently with the identified youth.   Siblings have not

routinely been considered since the focus was on the conditions of probation/sentencing of the Court for the identified youth. However, through preparation for the CFSR, the AFCARS review, and discussions with the Children's Bureau staff, we have identified our need to more comprehensively address the needs of every member of each family that is serviced by the Department. The mandate for Family Centered Practice has been initiated and the Program Improvement Plan will assist us to continue to move forward in ensuring safety, permanence and well-being for all of our children and families.

Frequency of Contact
The Department is keenly aware that frequent worker visits with parents and children can positively enhance the outcomes for families and children. By policy a social worker must visit a child/family once per month. Though this may seem infrequent, the practice is in part, because we purchase nearly all direct services for children and families and those vendors must have more frequent contacts, i.e., parent aides 2-4 times per week, parent educators at least 1 per week, etc. Our family centered practice initiative demonstrates the benefits of working more closely with families and that practice is being rolled out statewide, to juvenile justice youth and families as well. While we recognize the need for child and family contact we must also look at the workload demands on line staff and supervisors and identify those activities that have the least impact on positive outcomes. The ability to choose a face to face contact for the appropriate participant has been added to our RICHIST function. With re-education on this issue, and with the CYACTIVE data report that goes monthly to Regional Directors we can begin to monitor our actual face to face contacts with children and families.

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2. **Educational Status of Children.** Examine any data the State has available regarding the educational status of children in its care and placement responsibility. How does the State ensure that the educational needs of children are identified in assessments and case planning and that those needs are addressed through services?

As the state child welfare agency, DCYF ensures the enrollment and attendance for children both in-home and in placement, and works with the schools and state Department of Education to ensure positive educational outcomes for children. DCYF does not conduct any formal educational assessments. When the case is open to the Department, educational records are requested from the child's school, and information is reviewed to determine his current educational level and educational needs. If we suspect that a child needs special education services, the DCYF caseworker works with parent and school in making the appropriate referral for a special education evaluation. The case plan contains educational information on school placement, grade level, and special education eligibility. Specific tasks may be assigned in the case plan depending on the needs of the child (i.e., parent may be required to ensure that a truant child attends school). School progress is monitored on an ongoing basis through consultation with parents, school personnel, and attendance at school or Individualized Education Plan (IEP) meetings as necessary. School attendance and performance is reviewed as part of the Administrative Review Unit meetings.

Rhode Island States Child and Family Services Review Data Profile, June 20, 2003

By state law, DCYF has educational responsibility for youth placed in secure placement settings such as the Rhode Island Training School (RITS), Ocean Tides, North American Family Institute Ace Program, and Eckerd Camp E-Hun-Tee. DCYF operates the RITS, and contracts with each of the other the programs for educational services, and provides supplementary services with IDEA, Title I, and Title II federal dollars. All programs maintain a school program fully approved by the Rhode Island Department of Education, participate in the state assessment program, and provide supplementary educational services supported by federal grant program. For children in these programs only, DCYF is responsible for conducting educational assessments and developing an Individualized Education Plan (IEP) if necessary. This is approximately 345 youth at any given time.

DCYF has an agreement with the Rhode Island Department of Education (RIDE) regarding the provision of educational surrogate parent services to children in care who are eligible or may require special education services. When a child has been identified as eligible for special education services or DCYF suspects that a child may require special education services, and the parent is unable or unavailable to exercise parental rights in the special education process, an educational surrogate parent is appointed for the child by the RIDE. That person ensures that the child receives appropriate special education services. The DCYF caseworker and educational surrogate parent communicate to ensure the child's needs are met.

DCYF also employs an educational services coordinator who represents the department on RIDE planning initiatives. The educational services coordinator regularly attends the R.I. State Special Education Advisory Committee, the R.I. Transition Council, and the RIDE Advisory Committee for Alternative School Programs. She also liaisons with school and DCYF staff in resolving issues related to educational services for children in DCYF care.

The relationship between DCYF and the Local Education Agencies (LEAs) varies, and is based on individual contacts and relationships as opposed to formalized agreements between DCYF and the LEAs. Despite state law and policy which provides for the immediate enrollment of youth in school, DCYF sometimes experiences delays in enrollment and difficulty with transfer of records. There is a process to resolve these issues through RIDE, but work needs to be done to ensure prompt enrollment and continuity in educational placement.

The DCYF caseworker is responsible to ensure that a child is enrolled in school, but actual enrollment may be done by the parent or provider. DCYF policy 700.0150 details the enrollment process for children in care.

The Department maintains a report in its RICHIST system on all children with an active case. As of September 30, 2003, there were 5,667 children open to the Department. Of this number, 2,846 were in placement and 2,821 were in their own home. Nearly half (45%) of the children in placement, 1,556, are school age between the ages of 5 and 16. Some children in DCYF care are eligible for the appointment of an educational surrogate parent when the biological parent is unavailable to make educational decisions in the special education process. The educational surrogate parent program represents approximately 950 children at any given time. Our data system, RICHIST, has the capacity to collect educational data on the school to which a child is enrolled, special education eligibility, and primary special education disability; but, the accuracy

and availability of these reports is still a work in progress. The performance indicators for contracted programs capture this data for children in care and with re-education and supervision we expect to increase the quality and quantity of input of educational data into RICHIST so it can be measured as well.

The Department maintains a yearly census of residential beds for youth in placement, and according to the last census in December 2002, there were 544 licensed beds represented in group homes, shelters, and supervised apartments. Of the number of youth in these placements, 304 (54.87%) students had Individualized Education Plans. Children with special education needs are well represented by the Educational Surrogate Parents Program. The challenge, however, is to improve linkages for parents of children not involved with this program, and this may require more training and support around education issues. The challenge for DCYF is to improve RICHIST data collection and reporting on educational data and to improve collaboration and relationships with schools at the Department and regional level regarding planning and service delivery for children.

RI Data Analytic Center, FY02 Fourth Quarter Education Data
The Data Analytic Center at Yale University provides the Department with quarterly reports on a comprehensive list of performance measures from contracted providers, including education information. Based on information included in the fourth quarter report for Fiscal Year 2002, providers reported on one-half to two-thirds of the 1,025 school aged children whom the residential providers served in the quarter. This reflects of low reporting among the providers, but the information does provide the Department with some information on the educational status of children in care:

- Data for 4th quarter showed 96 school aged children were served in foster care. 94 (98%)of children in foster care attended school regularly. Math grades were reported for 76 children.

- Of these, 67 (88%) received a "C" or better. English grades were reported for 71 children. From these, 60 (84%) children received a "C" or better in English.

- For residential programs, 355 school age children were served in 4th quarter. Attendance reports on 315/355 showed 80% attended regularly. Math grades were reported for 264 children and 209 (79%) received a "C" or better. English grades were reported for 266 children. Of those, 207 (78%) received a "C" or better.

The data from Yale University is a good initial effort in reporting educational outcomes for children in out-of-home placement; however, the Department needs to continue to refine the performance measures and increase the reporting rate from the providers in order to establish a consistent means of monitoring the educational achievement for youth in care. The DCYF also needs to provide stability and continuity in the educational placement if a residential change becomes necessary. Lastly, we do not capture in RICHIST the number of youth who graduate high school or complete their GED. Significant measures like that will be considered on our list of priorities as we move closer to our Program Improvement Plan. While we can report on how

many youth are taking advantage of the college scholarship fund, we cannot report any additional related data.

Additionally, Rhode Island is committed to assisting youth to leave the Department's care prepared to transition successfully to adulthood. As part of that commitment, we are dedicated to enhancing the educational outcomes of youth, including increasing the numbers of youth who complete high school and enter post-secondary educational programs. This commitment is reflected in several activities, including preparation for higher education during high school, recognition for high school/GED completion and opportunities for financial and casework support during post-secondary education. As stated earlier, the Department has approximately 840 youth aged 16 and older in its care, and opportunities for life skills development and educational achievement are very much at the forefront of efforts to prepare these youth for self-sufficiency as they leave the Department's care.

In 1999 DCYF and its Youth Advisory Board successfully advocated for state legislation which would enable youth in out of home care to attend Rhode Island State colleges/universities free of expenses for tuition, room and board, books and supplies. That legislation, the DCYF High Education Opportunity Incentive Grant, originally provided $50,000 and increased by $50,000 per year for four years to the current level of $200,000 provided annually for youth.

During the 2002-03 school year, 44 youth attended Rhode Island's public colleges and university, compared to a total of 12 youth benefiting from higher education opportunities in 1999-2000. Of the 44, nine youth attended the University of Rhode Island, nine youth attended Rhode Island College, and 26 youth attended the Community College of Rhode Island through these Opportunity Incentive grant funds.

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3. **Health Care for Children.** Examine any data the State has available regarding the provision of health care, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), to children in its care and placement responsibility. How does the State ensure that the physical health and medical needs of children are identified in assessments and case planning activities and that those needs are addressed through services?

Nearly all of the children and youth in substitute care have their health and behavioral health services covered by Neighborhood Health Plan of Rhode Island and Beacon Behavioral Healthcare Strategies, one of the state's Medicaid managed care providers. The Department entered into an agreement with the Department of Human Services, the Medicaid Authority, in 1999 to enroll children in foster care into the managed care health plan, which began in November 2000. This coverage ensures that the children/youth have a medical home and that their treatment needs are assessed and provided for as they come into care.

The process for this has been evolving over the past few years, and NHPRI has been actively involved with the Department to develop mechanisms for linking children and youth to necessary appointments for assessment and working with the social work staff to ensure follow

up treatment and care as necessary. In fiscal year 2002, approximately 2,200 children/youth in foster care and residential programs had RIte Care coverage.

Many of the families involved with DCYF have their health coverage through RIte Care. It is a health insurance program that provides comprehensive health care for families receiving assistance through the Family Independence Program (TANF) and eligible uninsured pregnant women, parents, and children up to age 19 with. The income limits are very broad and include pregnant women up to 350% of the Federal Poverty Level, children up to 250% of the FPL and (non-pregnant) adult parents up to 185% of the FPL. For example a family of four could earn as much as $34,040 per year and still qualify for RIte Care; the children in a family of four could qualify as long as family income is less than or equal to $45,999 and a pregnant woman in a family of four could qualify as long as family income is less than or equal to $64,400. Through RIte Care, families have access to a variety of services including mental health and substance abuse treatment. RIte Care also provides transportation to appointments. RIte Care has received national recognition and praise for its success. As Rhode Island families have better access to health care, there may be fewer incidents of neglect and abuse, thus, RIte Care may be a factor in the reduction in the number of investigations.

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4. **Mental Health Care for Children.** Examine any data the State has available regarding the mental health needs and status of children in its care and custody. How does the State ensure that the mental health needs of children are identified in assessments and case planning activities and that those needs are addressed through services?

As already noted, the Department of Children, Youth and Families has the combined responsibility for child welfare/child protection, children's behavioral health, and juvenile corrections. Children's mental health needs are addressed across the Department.

- Children/youth coming into care on abuse/neglect petitions are given necessary assessments and treatment with therapists, often trained in areas of specific treatment needs to help youngsters understand and deal with trauma they have experienced.
- Parents may turn to the Department for public assistance if their child needs residential treatment that their insurance cannot cover. In these situations, a parent will seek a voluntary placement and the Department will obtain a miscellaneous petition in Family Court to be able to provide continued services without the family needing to relinquish custody.
- Youth sent to the Rhode Island Training School for Youth (RITSY) are able to receive mental health services at the direction of a psychiatrist and a Ph.D. level clinical psychologist and clinical social workers assigned to work with them.

As referenced previously, nearly all children and youth in substitute care, approximately 2,200 in foster care and residential programs, have their health and mental health care covered by the

Neighborhood Health Plan of Rhode Island (NHPRI). Neighborhood Health Plan of Rhode Island has a significant role providing care management for children/youth in DCYF custody, enhancing our case management and ability to access resources and services. The Department and NHPRI are working collaboratively to develop new behavioral health services for children throughout the system. As mentioned earlier, a new screening tool developed jointly by NHPRI/Beacon with DCYF is being used to assist social workers to assess the physical and mental health care needs of children/youth entering foster care for the first time, in order to better coordinate and if necessary expedite services and treatment.

Another 3,400 families are involved with DCYF with their children being maintained in their own home. These families would have their own health care coverage, generally. But if not, the Department pays for all necessary treatment services directly on a fee for service basis. Additionally, in the past three years, the Department has been steadily moving to increase the availability of therapeutic and clinical services in all of its residential programs. This is designed to assist in providing appropriate on-site clinical support for the children/youth in care, and guidance for staff in the programs.

During the past two fiscal years, the Department has participated in a national Children's Mental Health Benchmarking Project which represented 41 jurisdictions including 36 states. In this project, the DCYF and DHS collaborated in identifying mental health expenditures and services that were provided to children and youth with Medicaid funds. In FY 02, the DCYF reported that 2,261 children/youth between the ages of birth to 21 received some mental health service, of which 1,402 were children/youth in foster care. Within this total number, the Department reported that 261 children/youth experienced a psychiatric hospitalization during the year. The DCYF also reported that 915 youth at the RITSY received some mental health service in FY 02.

The mental and behavioral health care needs of children and youth are assessed for their well-being when they enter DCYF care or custody. Generally, a new assessment is conducted any time a child begins services with a new therapist or program. There is cause for concern, however, that changes in placement often require a youngster to begin therapy with a new clinician, thereby disrupting the therapeutic relationship that was previously begun. At present, there continues to be a lack of appropriate and necessary treatment options for children in need of mental health services throughout the continuum of care, particularly to address the needs of children/youth who are stepping down from more intensive levels of treatment. The Division of Children's Behavioral Health, with other state agencies and community providers, is working toward the development of a full continuum of children's mental health services that are based on maintaining a child's continuity of care throughout the treatment process.

The Department's creation of the Managed Networks is representative of our commitment to have services provided in the least restrictive manner possible ensuring a continuity of care for the children/youth involved. Further, toward the development of a continuum of care, this past year, the Department expanded its behavioral health capacity by opening one additional residential counseling center, and enhancing the capacity of another program. The Department also recently issued Letters of Interest (LOI) for residential treatment programs to enhance the State's capacity for higher-end services to meet the needs of children/youth either returning from out-of-state residential treatment or stepping down from treatment in a psychiatric hospital. As

mentioned earlier, two of these residential treatment programs will be developed within the next year.

A second Letter of Interest was issued to develop capacity for developmentally disabled youth with co-occurring behavioral health treatment needs. These programs will begin within the next 6-12 months, primarily to meet the needs of disabled youth who are currently being treated in psychiatric hospitals due to a lack of appropriate programs within the community.

The Division of Children's Behavioral Health is also working with the Department of Human Services and NHPRI/Beacon Healthcare Strategies to develop a shorter term intensive residential treatment program, as referenced earlier, to fill a need for youth stepping down from a more acute treatment setting, or preventing youth from needing treatment in a psychiatric hospital. This intensive residential treatment center will be developed inn the next year.

The Utilization Review (UR) program through Placement Solutions provides a quality assurance check on the activities of the higher-end programs, reporting regularly to the Department on the transition planning needs for youth in these programs. The Department's program monitors regularly review the records and treatment plan goals of youth in less intensive contracted residential programs, working with Family Service Unit social workers to assess the ongoing treatment needs and transition plans. And, as mentioned elsewhere, the Data Analytic Center at Yale University also collects information from residential contracted providers, and provides the Department with aggregate information on identified service needs, e.g., mental and behavioral health assessments among youngsters within the programs, and how well these needs are being met.

The Division of Children's Behavioral Health oversees a Diagnostic Assessment Service (DAS) program which serves as a central screening point for the mental health needs of youth who are presented before Family Court on wayward/disobedient petitions. These assessments may be developed through residential and outpatient services. Both assessments are comprehensive, but the residential program has a ten day length of stay designed for a more intensive level of assessment as may be determined by the Family Court. The assessments are provided to DCYF and the Family Court for further determination of service needs for the youth and, historically, this has often resulted in placement within DCYF. With the enactment and operation of programs under Article 23, however, the Department is already experiencing a noticeable change in the volume of wayward/disobedience petitions before the Court, and the Department is optimistic about the positive impact this service will have long-term.

A sex offender treatment program was just established in the Rhode Island Training School for Youth (RITSY) as a result of a Letter of Interest issued last spring. This program will begin a systemic approach to effective, evidence-based treatment for youth adjudicated for sex offenses and serving their sentence at the RITSY. The Department is now beginning to focus efforts on establishing a strong after-care component to manage risk and ensure public safety for youth being discharged from the sex offender treatment program back to their community.

The Division of Children's Behavioral Health also administers a program for youth being discharged from the Training School at the end of sentence. This federally funded program

known as Project Hope is a project through the Substance Abuse, Mental Health Services Administration, Center for Mental Health Services. Project Hope meets with the youth and family member to conduct a strength based assessment and discuss what services will be essential in assisting the youth to remain in the community and avoid re-incarceration. A community planning team/child and family team meeting composed of the youth, the parent/caretaker, the informal support network, and significant community providers (including but not limited to the youth's mentor, job coach, clinician, etc.) takes place preferably prior to discharge for the development of a youth specific service plan. The Family Service Coordinator ensures implementation of the plan through on-going contact with the youth, the youth's family, and/or service providers that are included in the plan. This contact is provided to the youth and family during the period when the youth is concluding their sentence at the RITS and for a period of nine (9) to twelve (12) months following discharge. Throughout the youth and family's involvement, this planning team is brought back together to change or modify the youth's plan as needed or desired by the youth and family. Services and supports are funded through traditional resources such as Medicaid and other insurance programs and non-traditional resources such as wrap-around funding.

Rhode Island's Child and Adolescent Service System Program (CASSP) is a system of care to provide family support and wraparound, non-traditional services for children and youth who have a serious emotional disturbance. The CASSP model began nearly 14 years ago with a grant from the National Institute of Mental Health (NIMH) in 1990, administered by the Department for Children, Youth and Families. At the conclusion of the grant in 1999, the state legislature, impressed by the positive outcomes for children and families involved with the CASSP system, appropriated funds in DCYF's budget to sustain and effectively institutionalize the CASSP model in Rhode Island. The goal of CASSP in Rhode Island continues to be the development of an integrated and comprehensive system of care for a target population defined as those children and youth in out of home placements, or at risk for entering out of home placements, due to serious emotional/behavioral disorders. The CASSP system is implemented through the Local Coordinating Councils (LCC's), which are located in eight mental health catchment areas's of the state. The LCC's are made up of representatives from mental health, education, child welfare, social service, and recreation agencies, parent advocates, and parents. This body works collaboratively with social service and mental health agencies, schools, and with the CEDARR family centers, referenced earlier, to ensure that wraparound services throughout a continuum of treatment needs are accessible to families and that families are integral partners in determining the best service plans for their children and them selves. In this past fiscal year, the Rhode Island CASSP system has served approximately 1,000 families.

Over the past two years, the Division of Children's Behavioral Health has been working with the Department of Human Services and the community mental health organizations, families and other providers to restructure the Children's Intensive Services (CIS) program. This is an intensive mental health services outpatient program to meet the needs of children/youth who are seriously emotionally disturbed. This service works very closely with the CASSP/LCC system. The restructuring was a response to the changing needs of the population and the system development toward a full continuum of care. The CIS program, as referenced earlier, provides services to an estimated 2,200 children and youth, not necessarily involved in DCYF; though, some estimates in RICHIST suggest as many as half of the youth receiving CIS services are

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involved with DCYF. In the Children's Mental Health Benchmarking Project, the DCYF reported that 14,005 children/youth received some outpatient service in FY 02. These services include CIS for Medicaid eligible youth, CIS for non-Medicaid eligible youth, as well as traditional outpatient services that DCYF covers for youth who otherwise do not have insurance coverage; e.g., youth in DCYF care living at home with their parents.

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5. **Other Well-Being Issues.** Discuss any other issues of concern, not covered above or in the data, that impact on the well-being outcomes for children and families served by the agency.

#1   As already noted, visitation is one of the most critical activities that can occur between families and caseworkers, and children and caseworkers, as caseworkers continuously assess movement toward achieving safety, permanence and well being. By policy, as already mentioned, a social worker must visit a child/family once per month. Though the Department's contact is infrequent by policy, this is explained, in part, by the fact that we purchase nearly all direct services for children and families and that those vendors must provide more frequent contact with the families and with our staff. We believe that more frequent contact is beneficial to all parties but demands have negatively impacted time with families, i.e. caseload, court, federal and state requirements which require in office, at computer, documentation, transportation, etc. We have recently enhanced our documentation tools to include a case activity note specific to face to face contacts with children and families so that we will be able to track that vital information over time. Managers receive a monthly report which outlines vital activities, i.e. completion of case plans, etc. Managers will be able to track the time spent with families per worker, unit and in the aggregate for all staff. Managers will be able to track the number of contacts with families per worker, unit and in the aggregate.

We need additional training and supervision to support that effort and a concerted effort to determine how to identify those activities most associated with achieving positive outcomes. We also need to evaluate which current responsibilities of all line staff could be eliminated or transferred to others.

#2   The RITS Youth Correctional Education Center (YCES) is fully accredited as a Local Education Agency (LEA) by the Rhode Island Department of Education. All residents are required to attend school daily, and we provide both regular and special education classes. We keep an educational file (hardcopy) on each youth in the YCES, that includes current school progress in the YCEC (report cards, IEPs, educational evaluations, etc.), records from past school districts, and information about transition back to the public school district. We also keep some information in an ACCESS data base maintained within the YCEC. The RITS educational program receives Title grants (I, ii, IV, V,), IDEA, and Perkins. Last year they received a small library grant.

#3   The RITS maintains a clinical director who contracts with Lifespan for medical, dental and psychiatric services. Medical records (hardcopy) are kept in a separate file in the nurses'

clinic area. Mental health needs are recorded in each youth's "clinical file". The Director of clinical services oversees both of these and a Quality Assurance Coordinator is particularly involved with the bi-monthly review process. The RITS also pays for mental health services that are identified in the individualized treatment plans for youth on a fee for service basis. There is also a substance abuse treatment unit on the grounds providing specialized services for youth at the Training School.

The Rhode Island Family Court has established a Juvenile Drug Court program that seeks to combine the coercive powers of the court with a therapeutic regimen to foster rehabilitation of and accountability in substance abusing juveniles and their families. The program goals are to reduce delinquency and alcohol or substance dependence among juvenile offenders, as well as to integrate the juvenile justice system with the therapeutic community in order to maximize a juvenile's opportunities and likelihood for success.

Section V - State Assessment of Strengths and Needs

STRENGTHS

There are few more complex and difficult jobs in public service than that of DCYF investigator, social worker, probation officer or juvenile program worker. The dedication of the staff to better the lives of the children and families they serve is remarkable in the best of times. It is more remarkable now under budgetary constraints leading to staff vacancies, increased workload demands, technological enhancements leading to increased need for training, time spent at one's computer, and demands for adherence to federal and state regulations, and compliance documentation.

We must be ever mindful of this environment when we develop our Program Improvement Plan (PIP). Supervisors and line staff need to be involved in decisions regarding practice changes. A close look at what is essential to achieving safety, permanence, and well-being outcomes must drive our determination of what activities are assigned to line staff and supervisors, and what activities can be assigned to others or eliminated.

Our improving executive level relationship and collaboration with Family Court on calendar scheduling, permanency hearings, decrees, expansion to juvenile justice cases, language, effectiveness and tracking, as well as accommodations for line staff awaiting hearings and openness to ongoing training for court, legal and line staff, are all reflective of the strength with which the larger system is evolving.

Family Centered Practice was identified in our Pilot CFSR, 2000, voluntary PIP. As we outlined in our assessment we have made progress on our inclusion of the family in:
- team meetings,
- case plan development,
- identification of services and providers, and
- permanency decisions

We have achieved positive outcomes as a result. We know that relationship and permanency success comes from these practices; and, at the same time recognize that we must continue to strengthen our staff competencies and examine caseload demands if we are to continue achieving success throughout the agency-wide implementation to all family service and juvenile justice staff.

Adoption practices have consistently achieved conformity on the National Standard. While we had some technical difficulties that have been corrected which may have somewhat inflated the numbers and percentages, we believe that we have consistently met and surpassed the national standard. Our enhanced adoption efforts began prior to the implementation of ASFA with Rhode Island specific laws and practices that foster those achievements. We also maintain a successful collaboration with the adoption service providers and are working with them to develop a curriculum leading to a specialization in adoption practice for mental health professionals. We are using the approach we were successful with in developing training and experience criteria for specialization in child sexual abuse evaluation and treatment.

Our SACWIS System, RICHIST, Data Analytic Center (DAC), and Utilization Review (UR) contract have greatly increased data to inform decision making. Upgrades and fixes to RICHIST have had an extremely positive effect on our MIS function, culture, and quality. Our DAC partnership efforts with Yale University and the University of Rhode Island has increased our ability to produce and analyze longitudinal data and analyze and capture performance measures for all of our contracted programs. Our UR collaboration with Placement Solutions has assisted us in achieving impressive and positive results in bringing Rhode Island youth back from out of state and distant residential treatment facilities and increasing our in-state and therapeutic foster care options. Our need for ongoing data sort and analysis capacity is also a challenge as described in our areas needing improvement.

In our Juvenile Corrections Division, plans are under way for construction of a new training school facility near the site of the current one in Cranston. Years of overcrowding and limited program space has led the State to approve funding for this vital project. The new facility will greatly enhance the Department's ability to effectively house and program for the skills leading to successful re-entry of youth into their community. The Juvenile Probation "Safe Streets" project is an innovative and promising program which collocates juvenile and adult probation under a single supervisor together with Providence police staff in the police facility. Immediate collaboration, availability to be in the community and during non-standard work hours ensures more effective oversight and response to the most at-risk youth and young adults. Also, Project Hope has been recognized as a "Promising Practice" by the Department of Justice.

The Rhode Island Child Welfare Institute merged with Rhode Island College School of Social Work in June of 2001. This is a collaborative effort between the Department and the School of Social Work. The Institute is responsible for education and support of the nearly 900 staff within the Department. The CWI offers comprehensive in-service training for all staff, as well as a 6-month pre-service program for Social Caseworker II staff. They also coordinate a growing internship program for the Department which places both undergraduate and graduate level students in many challenging divisions within the Department. The CWI is also involved in

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innovative child welfare projects, such as the development and implementation of our Family Centered Practice imitative. A community advisory committee which is made up of both public and private child welfare professionals, as well as individuals in related academic fields from several colleges in Rhode Island, serve as advisors to the Institute.

Rhode Island's RIte Care program is a nationally recognized health initiative, which is delivering health care to a greater percentage of children and families than any other state. It plays an important role in preventing the neglect of health care for children and youth as well as ensuring the provision of physical, emotional, behavioral and dental care to children in out-of-home care. Neighborhood Health Plan of Rhode Island is the major provider of services and they have been extremely responsive to the special needs of our children and families. Evaluation and treatment of emotional, behavioral, physical and dental needs as identified in the case plan are a covered service. They also maintain easy access to specialized care managers to problem solve our unique and complex situations.

The government, faith, provider, and family support communities have played a vital role in identification and attempts at resolving our areas needing improvement. The most recent example of our collaboration with these entities was the work of the System of Care Taskforce and subsequent report *Toward an Organized System of Care*; and, their ongoing contributions to the development and implementation of a system of care that will be responsive to the needs of the children and families we serve. Additionally, the provider community has responded enthusiastically to our call for networks of care wherein youth accepted into a network receive a full continuum of services without experiencing ejection. Care Management Teams have ensured a much enhanced and inclusive opportunity for providers, educators, mental health professionals and families to join with our staff to address the need for specialized placement services.

The statewide community accepted and assisted in building a uniform and community-based response to address the needs of families seeking to file a Wayward/Disobedient petition on their youth to secure services. Each community now has a community-based service system in place to prevent placement, where appropriate, and ensure the provision of local evaluation and treatment services.

Our collaboration with sister State agencies that share responsibility for the children and families served by our Department has been further enhanced by the efforts of the Governor's Children's Cabinet. The System of Care Taskforce design has been supported by the Governor and its implementation is designated as the major priority of the Cabinet. In addition to ongoing joint efforts between the major state departments, implementation of the System of Care requires all agencies to contribute to and support the achievement of the outcomes associated with the system's success.

When the administration of State government transitioned from Governor Lincoln Almond to Governor Donald Carcieri the Department developed a transition plan which is included as an Addendum to this report.

AREAS NEEDING IMPROVEMENT

A typical night-to-night placement is an unplanned placement for one night only, with a plan to pick up the child in the morning and return to DCYF to await further identification of a placement. During this time, a planned 90 day (or greater) placement is sought. While the number of episodes in the last six (6) months has reduced from a high of 122 to 6, experience has demonstrated that in spite of our best efforts to predict and prepare in advance of spikes, they continue to occur. Most recently, we have gone 38 days without a child experiencing a night to night placement. Our best placement data from RICHIST, CMT's, etc. is being fed to our Resource Management Team in a continuing effort to prevent youth in our care from experiencing the instability of a night-to-night placement.

We have been working with the National Resource Center on Child Maltreatment, our Data Analytic Center, and conducting case analysis in three critical areas associated with the safety of our children and youth. As indicated earlier, the preliminary results of our repeat maltreatment analysis validate our sense that we are investigating some families multiple times before achieving any successful conclusion. We believe that is not only resulting in re-maltreatment for Rhode Island children and youth but diverting precious dollars to investigation that ought to be going toward treatment that resolves the child and family issues. We currently have some very successful community programs, i.e., CES, PES, Family Renewal, Project Family, etc., that assists us to divert families in a timely manner from our system to a community-based treatment program. We know that we need to expand these programs and involve others to include home-based mental health, home based parenting/support and behavior management, more immediate mental health assessments – followed by fast access to on-going treatment, respite, outreach and tracking, and ensure that families are seen very quickly and do not experience a waiting list for such vital services. This affords the family the timely services they need and could eliminate duplicative investigations followed by little and/or untimely intervention. The budget crisis in Rhode Island requires that we take yet another look the families we are serving, why, when, and with what results. We have begun discussions about how to narrow the door to ensure families with identified service needs, for whom no legal status exists, and could not be obtained, could be successfully treated within their neighborhoods and communities, quickly and effectively. Department and community representatives are focusing on this initiative with an eye toward the timeliness of our Program Improvement Plan.

Not unlike many other states, Rhode Island is experiencing a severe budgetary shortfall. We are being asked to do better differently with less and as a result the Governor has just completed an evaluation of all State Agencies, by State Agency personnel, called "Fiscal Fitness", in an attempt to find less costly ways to deliver the needed state services. The recommendations from this effort are just now being unveiled and discussed.

The current level of vacancies across all line staff positions is the most severe that the Department has experienced for many years. As we seek to comply with the CFSR's 51 performance measures to achieve conformity, we will be hard pressed to change existing practices and/or implement new practice with an already overburdened staff. Also, not unlike other states we have an aging workforce and we continue to see a rise in the retirements of our most experienced administrative and supervisory staff.

We do not have a Quality Assurance System that meets the requirements of the CFSR. In spite of our current workload demands, we have begun our CFSR and PIP process by using federal dollars to free up a full time administrator to manage the process and begin to identify how we can build a QA/QI function. The Integrated Planning and Evaluation Team have been given the responsibility to oversee the formation of a plan for Continuous Quality Improvement throughout the Department. A subcommittee of that Team has begun meeting and will, by March have mapped a proposed QA/QI function across the Department and will have identified the critical staff needed to bring further detail and bear responsibility for those functions. The QA/QI function will play a critical role in our PIP and measurement of outcomes as a result of changes in practice.

Additionally, we know that we are in a good position with our RICHIST system, Data Analytic Center, Child Welfare Institute and UR efforts. We now need to enhance and coordinate our data sort and analysis skills to ensure that the data available to us will be understood and sufficient to identify the practice changes necessary to improve outcomes. We have been very successful at identifying the issues for the Data Analytic Center to study, we have not been nearly as successful in applying those results to practice changes with an eye toward improved outcomes. Our first DAC Data Conference will be held in January 2004 to inform all staff of our standings as compared to the National Standards, our in-state capacity building that has resulted from our UR with out-of-state residential treatment facilities, and lastly the findings from the permanency and placement studies completed by Yale. Staff will be strongly urged to recommend practice changes based on this data.

We have given our newly created Integrated Planning and Evaluation Team the responsibility for recommending to the Senior Executive Team future planning, prioritization and evaluation. Those team members have a full commitment of time and responsibilities elsewhere in addition to the new team requirements. The first priority of the Team is to facilitate communication so that staff and the community have real time knowledge of and opportunity for input into the major research, planning, practice and evaluation efforts across the Department.

Rhode Island's Department of Children, Youth and Families is charged with responsibility for all youth services, including juvenile justice and mental health. Our practice and philosophy in Juvenile Probation and at the RITS has been directed specifically to the offending youth and the Court conditions of probation or sentencing. We are now complying with ASFA for youth on probation with respect to the development of a case plan, permanency planning and permanency hearings that meet federal requirements. Much additional work needs to be done to incorporate our Family Centered Practice efforts, as well as address and record safety and well being.

Juvenile Corrections staff in every case and Family Service staff for some cases will need to add an additional assessment of parents and/or siblings, and the potential resulting service referrals will create an as yet unestimable demand on caseloads already averaging in the 60's in probation.

Guardianship is acknowledged and accepted by the Department as a viable permanency plan opportunity and encouraged where appropriate. Our use of guardianship, as recorded in the data profile, is quite low. Policy and practice only limits guardianship for the youngest of children for

whom, we believe, adoption presents a great assurance of permanency.   The barrier to guardianship may well be financial, as the economics of guardianship have been less attractive than that of adoption. The state provides guardianship subsidy if the guardian is not related but at a rate equivalent to TANF reimbursement. Where the child or children may be eligible and receiving above board rates for special needs, the TANF payment can represent a major decrease and therefore deterrent. More analysis needs to be completed in order for us to address this issue in our Program Improvement Plan.

Based on examination of the data in section III and the narrative responses in sections II & IV, the State Review Team should respond to the following questions.

Below is guidance for States in completing Section V, State Assessment of Strengths and Needs, of the Statewide Assessment Instrument:

V1: Determine which of the seven outcomes and systemic factors examined during the Statewide Assessment are primarily strengths and note them.

V2: Determine which of the seven outcomes and systemic factors examined during the Statewide Assessment are primarily areas needing improvement and note them. Identify those areas needing improvement that the State would like to examine more closely during the onsite review, for example, to explore possible causal factors. Prioritize the list of areas needing improvement in relation to the outcomes of safety, permanency, and well-being.

V3: Recommend two additional sites (the State's largest metropolitan area is a required location) for the onsite review activities using the strengths and areas needing improvement noted in V1 and V2. Attempt to select sites in which issues identified through the Statewide Assessment will be present and observable. Note the rationale for selecting these sites; if there are no issues that require further examination during the onsite review, explain which factors the State considered in site selection (for example, to create a mix of rural and urban areas, or to include areas with typical practices).

V4: Provide comments about the State's experience with the Statewide Assessment instrument and process (this information will assist ACF in continually enhancing the child and family services reviews' procedures and instruments).

> V5: Provide the names and affiliations of the individuals who participated in the Statewide Assessment process; please also note their role in the process.

1. What specific strengths of the agency's programs has the team identified?

- The professional and dedicated staff doing this most critical work with children, youth and families.

- Our improving relationship with the Family Court enhances our ability to work together to achieve permanency and free up staff time to work directly with, as well as for, families.

- Our family centered practice demonstration and statewide roll out following our pilot review in 2000. This return to basics has enhanced our work with families and demonstrates their increased level of involvement in planning and decision making and ultimately permanency decision making.

- Our adoption practices and outcomes. We have made many enhancements to recruit, train and support adoptive families to achieve permanency for our most difficult children and sibling groups.

- RICHIST, DAC, UR – when you think that six or seven years ago we didn't even have computers on our desks and now we not only have an automated system but with continued enhancements and data cleanup efforts we are poised to identify and retrieve the appropriate data which will inform practice and improve the outcomes for those we serve. The marriage of RICHIST with our DAC and UR functions has enabled us to get a clear picture of those youth placed in distant out of home placements and return them to Rhode Island to an appropriate program. It has also played a vital role in evaluating a critical mental health service i.e. CIS so that the previous one fixed level of service as to length of service, intensity of service, etc. is now a flexible 4 level menu with level assignment based solely on client presentation and need.

- Our new RITS facility plan and funding is in place and will greatly enhance our services to youth sentenced. Our Safe Streets initiative is innovative, effective and demonstrating successful collaboration.

- RIte Care is a nationally recognized health care program that is meeting the needs of our unique population of kids in care with services for physical, mental and dental care while reaching families not known to us and providing care that results in preventing physical, mental and dental neglect.

- Collaborative efforts with the governor's office, sister state agencies, legislators, Family Court, provider networks, faith community, families and youth have led to a System of Care reform, networks of care to ensure stability of youth in placement, passage of Article 23 to service rather than place disobedient adolescents, etc.

2.   What specific needs has the team identified that warrant further examination in the onsite review? Note which of these needs are the most critical to the outcomes under safety, permanency, and well-being for children and families in the State.

While the night to night placement of youth while greatly reduced through program development and expansion, we are not ready to say it has been solved and we continue to make it our number one priority to ensure the safety of children and youth requiring our care.

Given budgetary realities and our preliminary review of repeat maltreatment, we are looking for the onsite review to help us identify our practice and services for intact families. We believe that successful diversion of these families with a corresponding reduction in re-maltreatment is possible if we were able to develop and expand our ability to refer families for immediate and appropriate community, home based services.

Vacancies of line staff in all divisions cause us concern regarding our ability to train staff and implement practice changes leading to achievement of safety, permanency and well-being.

We lack a uniform and visible QI/QA system which impedes our ability to identify where, how and why we are and are not achieving our desired outcomes. A real time feedback loop to direct staff, supervisors and administration to inform us on practice will play a vital role in communicating trends in success and inadequacies. Key stakeholders and the community at large will also play an important role with us to measure our progress at the case and system levels and in the quarterly reporting on our PIP.

Related to our QI/QA function is our present inability to use data appropriately and consistently to inform practice to enhance outcomes.   We have been in a research and educational phase which needs to continue but we must also move quickly to develop the capacity and/or prioritizing necessary to achieve the analysis of data available to us.

Our juvenile justice practice has been focused on the identified youth and his/her conditions of probation or sentencing. We are progressing with the help of Family Court to include the requirements of ASFA language, permanency hearings, periodic review, etc. We have much more to do to conform to assessment of the family system with an eye toward safety, permanency and well-being. We must also look at the workload demands that will accompany the new practice for juvenile justice in particular but also for family service staff.

Lastly, guardianship as a permanency option is infrequently used. Whether that is because of policy, practice, training and/or financial disincentive is not yet clear to us. Analysis of this goal as a viable option must occur and inform so that children may experience permanency as quickly and appropriately as possible.

3.   Which three locations, e.g., counties or regions, in the State are most appropriate for examining the strengths and concerns noted above in the onsite review?

Regions 1, 3, and 4 because of their size and representation of the issues identified. Region #2 would not likely provide sufficient case numbers to achieve a sufficient number of in-home cases whether child welfare or juvenile justice. Additionally, the uniqueness of Region #2 is that they are home to our work with subsidized families who have adopted our children and are, for the most part, not a subject of this review.

4. **Comment on the statewide assessment process in terms of its usefulness to the State, involvement of the entire review team membership, and recommendations for revision.**

In spite of the numerous studies, task forces, community forums, etc. that the Department has participated in or hosted over the last year or two, the assessment of the Department required for the CFSR could not be achieved through those focused forums. The Statewide Assessment is our opportunity to have the community work with us to describe who we are, what we do and to the best of our ability how well we do it. It is also an opportunity to cultivate relationships with community providers so they will see the benefit of continuing to work with us through our PIP and over the two years of measurement. Providers tell us that they come to know and understand us better and how they interface with us through this process. This has been our second opportunity to work with the community in this way and it is clearly a win-win proposition for all involved.

5. **List the names and affiliations of the individuals who participated in the evelopment of the statewide assessment (please specify their role).**

The Oversight Committee Includes the following Community Representatives:

Maximo Arias, John Hope Settlement House
Tim Kelley, Joli Faucher, Devereux Treatment Centers
Michelle Duso, Youth Pride, Inc.   Betsy Ison, Placement Solutions
Pamela Watson, Family Services, Inc.
Carol A. Spizzirri, Consultant
Ed Rondeau, CODAC
Gwen Andrade Aponte and Mao Yang, RI CADV
Makara Khang, Joseph Lee, Socio Economic Development Center for Southeast Asians
Heidi Brinig, Childrens Museum

Roberto Da Silva and Nap Gonsalves,   Pawtucket Police Department
Darlene Allen,   Adoption Rhode Island
Chandra Jackson, and Binh Tran, Casey Family Services
Kate Begin,   Prevent Child Abuse
Scott Mueller, RI College, Family Services, Inc.
Craig Gordon and David Harlow,   Communities For People
Debbie Soares, Karen Peters-Bowden and Valentina Laprade Children's Friend and Service
Madeline Burgess, Kimberly Rose, Chafee Life Skills Center
Lisa Guillette, RI Foster Parents Association
Jill Fitzenmayer, Child and Family Services/Newport
Peg Langhammer,   Sexual Assault and Trauma Resource Center
Stanley Kuziel, Providence Center
Margorie Wynn, Patti Henna Adoptive Parents
David Tassoni, R. I. Family Court
Valerie Francis, Office of the Child Advocate
Michael Klein, Harmony Hill
Judy Crossman, Parents Support Center
Wenonah Harris, Tribal Child Advocate, Narragansett Indian Tribe
Dr. Chales Staunton, Butler Hospital
Laura Tuscani, Work Opportunities Unlimited
Amy Lockhart, Administration for Children and Families, Boston Region
Department Staff on the Oversight Committee
Elaine Squadrito, CFSR Project; and Lee Baker, Children's Behavioral Health and Education
Kevin McKenna, Juvenile Probation
Judy Malin, FSU
Frank Greene, ARU
John Farley, FSU
David Allenson, MIS

Sandy Woods, Substance Abuse
Cyndy Fontaine, FSU
Nancy Herrington, CBH&E
Kathy Letourneau, FSU
Beverly Turner, FSU
Suzanne Zuffoletti, FSU
Sue Carlson, FSU
Paula Fontaine, FSU
Janice Contillo, FSU
Joan Cicione, Policy and Practice Standards
Colleen Hedden, Educational Coordinator, CBH&E
Linda Essex, Care Management Team, CBH&E
Nancy Tierney, FSU
Kara Smith, FSU
Maureen Robbins, Adoption
Sue Bowler, CBH&E
Suzan Morris, FSU
Maureen Egan, FSU
Terry, Stefanie CPS
Joan Harmon, FSU
Linda O'Malley, CWI
Audrey Shaw, FSU
Karen DeOrsey Smith, CPS
Many additional staff were involved in the development of the Statewide Assessment without being official members of the Oversight Committee, i.e. Thomas Dwyer, Robert Carl, Kevin Aucoin, Leon Saunders, Leo Ducharme, Kevin Savage, Angelo Pizzi, and the Data Management Team, etc.

Addendum

I   [Toward an Organized System of Care for Rhode Island's Children, Youth and Families](#); *The Report of the Rhode Island System of Care Task Force (can be obtained electronically at http://www.dcyf.ri.gov/docs/tskfrce_final.pdf).*

TOWARD AN
ORGANIZED SYSTEM OF CARE
FOR
RHODE ISLAND'S CHILDREN, YOUTH AND FAMILIES

The Report of the

Rhode Island System of Care Task Force

January 2, 2003

Co- Chairmen:

Senator Thomas J. Izzo
Representative Steven M. Costantino
Robert L. Carl, Jr., Ph.D.

Additional copies of this report are available by the following means:

Electronic PDF Version:

RI Department of Children, Youth and Families Website: www.dcyf.ri.gov/docs/

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TRANSMITTAL LETTER

Hon. Donald L. Carcieri, Governor-elect
Governor's Transitional Office
299 Promenade Street
Providence RI 02903

Hon. William V. Irons, Senate President-elect
State House - Room 317
Providence RI 02903

Hon. William J. Murphy, House Speaker-elect
390 Wakefield Street
West Warwick, RI. 02893

Dear Governor-elect, President-elect and Speaker-elect:

Congratulations to each of you on your successful elections.

With this letter, we send to you the report of the Rhode Island System of Care Task Force and ask for your full support and your strong leadership in moving us closer to an organized system of care for Rhode Island's children, youth and families.

A major impetus for the creation of the System of Care Task Force was the study of the Department of Children, Youth and Families commissioned by the Children's Policy Coalition (CPC) and conducted by the RI Public Expenditure Council (RIPEC) [*A Review of the Department of Children, Youth and Families* prepared by the RI Public Expenditures Council and commissioned by the RI Children's Policy Coalition (January 2001)]. The System of Care Task Force took up where the RIPEC Study ended. Our report culminates nearly 2 years of data gathering, analysis, discussion and consensus building. The members of the System of Care Task Force unanimously endorsed the vision and principles of this report and acknowledged that considerable work needs to yet be accomplished.

This report builds on the strengths of our state's system of care, describes the challenges and outlines a plan to move a currently disorganized and fragmented system of care into an organized system of care. Our recommendations were developed through dialogue and consultation with family members, advocates, elected and appointed officials, judges, expert practitioners and other members of the public who are involved or have an interest in services for children, youth and families.

The work of the Task Force was divided among two data-gathering committees, the Foster Care Committee and the Current Reality Committee, and one design committee, the Ideal System of Care Committee. The former two committees were tasked with collecting data relative to their assigned areas, analyzing that data and forwarding it to the Ideal System of Care Committee. The Ideal System of Care Committee was tasked with using this and other input to present to the Task Force a plan that moved away from the traditional response to child and resource crises (adding more resources through additional funding with no

organized plan) to developing a structure for a new system of care that is family-centered, community-based and in which programs and services are measured against agreed upon outcomes.

The reports and the recommendations of the two planning committees are included as appendices to this document. The vision and structure outlined in the body of the Task Force report is based on the recommendations of the Ideal System of Care Committee. Our vision recognizes that the resource needs identified in the other two committee reports can be effectively addressed only through a true "paradigm shift" which ensures that we move to structures and processes which emphasize community-based prevention, strengthen families and communities and more clearly define the parameters used to determine when a child or youth is placed out-of-home. These details must be used to inform the work of those who are tasked with planning and improving Rhode Island's new System of Care.

As the leaders of the Task Force, we believe it important to point out two critical partners for moving ahead – the judiciary and the provider and advocacy communities.

Rhode Island enjoys a very active and involved Family Court bench which unquestionably seeks to ensure that children and their families are provided with the highest quality of services and supports available. The reality, however, is that the authority for expenditures and the control of those expenditures is extremely diffuse. As long as this diffusion continues, the State will have difficulty focusing on priorities, achieving the best possible outcomes and controlling expenditures. The challenge before us is to more clearly define roles within our system and thereby achieve greater quality, greater accountability and a more cost effective approach to delivering services and supports to children and their families.

Likewise, Rhode Island's provider and advocacy communities are aggressive in providing input and feedback, especially in regard to the functions and practices of DCYF. Two-thirds of DCYF's expenditures flow to private providers. We must continue to include these voices at the table while recognizing that some perspectives represent narrow interests and arriving at consensus for significant and critical improvements can be elusive.

Finally, the Task Force strongly endorsed the Children's Cabinet as the principle body to oversee the implementation of these recommendations. The Cabinet has become a truly effective vehicle for interagency collaboration and systems reform. We encourage you to use the Cabinet as the steering authority for the System of Care Implementation Committee modeled after the successful Welfare Reform and Starting RIght Committees. As described in this report, we see the Department of Children, Youth and Families (DCYF) as the lead agency staffing this committee with additional staffing commitments from each of the other executive departments that have the authority and responsibility for the delivery of health, human and educational services to our children, youth and families.

With strong state-level leadership, we know that the recommendations in this report will be used as a blueprint and catalyst for developing an organized system of care for Rhode Island's children, youth and their families. We seek your support and leadership. We look forward to discussing this with you in further detail.

Sincerely,

Thomas J. Izzo

Senator Thomas J. Izzo

Steven M. Costantino

Representative Steven M. Costantino

Robert L. Carl, Jr.

Robert L. Carl, Jr., Ph.D., Director
Department of Administration

PREFACE

The Rhode Island System of Care Task Force was charged to design a full system of services that will provide effective supports and services to children and their families. Looking beyond the current configuration of services, departments and providers, the Task Force worked to design a system that builds on the strengths of children, youth and families through the most effective use of finite state resources.

This System of Care for our state's children, youth and families is a vision. It is a proclamation of shared goals and a desire for better outcomes. The importance of this vision to our state and its future served to induce all three branches of government into its preparation. Critical to the lives of our most vulnerable citizens, Rhode Island's Legislative, Executive, and Judicial bodies are each charged with distinct governmental functions relative to our children and youth. By participating in this planning process, no branch of government has sacrificed any of its authority, power or obligation. Constitutional checks and balances set the context for this vision and comprise the legal foundation of governmental responsibility which may not unilaterally be abdicated. In this new Rhode Island System of Care, if each and every child and family is to succeed, all three branches of government must be vigilant in fulfilling their distinct roles in the lives of children, youth and families.

Integral to any effort on behalf of children and their families is understanding the role and authority of distinct government bodies.

The Family Court has the statutory authority to oversee and implement all the duties as enumerated within Chapter 1 of Title 14, Chapter 11 of Title 40 and any other statutory charge as outlined within Section 8-10-3 of the Rhode Island General Laws.

The Department of Children, Youth and Families has the statutory authority and responsibility to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children, youth and their families to reach their full potential, including prevention, early intervention, outreach, placement, care and treatment, and aftercare programs. The Department is the single authority to establish and provide a diversified and comprehensive program of services for the social well-being and development of children, youth and their families. In furtherance of its purpose, the Department of Children, Youth and Families cooperates and collaborates with the Family Court, other public and private agencies, and the federal government in the development and implementation of comprehensive programs to support children, youth and their families.

The Office of the Child Advocate, created in 1979, is statutorily charged with protecting the rights of children in State care. RIGL § 42-73-7 grants the Office of the Child Advocate the authority to take all possible action, including, but not limited to, public education programs, legislative advocacy and formal legal action, to secure and ensure the legal, civil and special rights of children.

While the Task Force made very effort to design a comprehensive System of Care, recognizes the challenges inherent in the implementation of any systemic change. Further, the Task Force recognizes that a body of law exists, both state and federal, which comprises the underpinnings of child welfare, juvenile justice, and children's behavioral health services. This report, its recommendations, and implementation plan must be viewed within that framework.

EXECUTIVE SUMMARY

This plan for an Organized System of Care for Children, Youth and Families is one that has been evolving for more than two decades. During this span of time, the system has grown -- with each attempt at crafting a better plan to ensure that children and families receive the right services to meet their needs. However, during these past 20 years, the growth has been biased in favor of residential treatment to the detriment of the development of community-based capacity that supports and engages families as partners in the helping process with children. We have not sufficiently invested in prevention or early intervention to identify and meet the needs of children, youth and families. There has been a paucity of data to guide better decision-making.

This plan finally establishes a foundation to act from national research and local knowledge. This report mandates a stronger, more urgent commitment to prevention and early intervention and education and, importantly, places a deep emphasis on ensuring an organized system of coordinated services and care.

Rhode Island's organized System of Care for Children, Youth and Families is built on the strengths of families and communities, the successes of past initiatives, and is responsive to the challenges of the past. It is a system that is operationally feasible, financially realistic and supported by broad consensus. This system is the strategic instrument for moving the State closer to the four outcomes embraced by the Rhode Island Children's Cabinet and other key state and community leaders:

❑ **All Children Entering School Ready to Learn**

❑ **All Youth Leaving School Ready to Lead Productive Lives**

❑ **All Children and Youth Safe in Their Homes, Neighborhoods and Schools**

❑ **All Children Living in Families that are Self-Sufficient, yet Inter-Dependent**

Within the pages of this document, there are three critical interwoven themes:

❑ **Family-Centered Practice;**

❑ **Prevention and Education; and,**

❑ **Promoting Best Practices.**

The fundamental values at the core of this plan are recognition and support for the role of the family as the primary caregiver for children, and that the optimum interventions for any individual child and their family are those most proximate to home with the full resources of the community made available to that child and family. This Plan also recognizes that "family" includes biological parents, adoptive families, extended kinship networks, legal guardians and temporary fostering families.

The Organized System of Care provides all families and primary care-givers ready access to the resources necessary to meet their child's developmental needs. The system has mechanisms to redirect cost savings from reduced reliance on restrictive and expensive out-of-home placements to community-based prevention and intervention services. Included among these resources are those that meet the basic needs of all children for healthy

development, as well as special resources to meet the unique individual needs of children with disabilities and social, emotional, and behavioral disorders; children who have been abused and/or neglected; youth involved with the juvenile justice system; and, young women, whose unique pathways into the juvenile correction system, and their special strengths and needs, have only recently come into view.

This plan envisions the Rhode Island System of Care as one built on principles of best practice and evidence-based results. Past experience has shown that government and private resources have continued to establish and support programs which show little evidence of positive outcomes for children, youth and families. This in turn has led to inadequate resources available to quality programs and services that provide promising or proven results. For Rhode Island's System of Care to make effective use of finite resources, all components of the system must follow best practice principles and ensure that each child is served in the most integrated and least restrictive setting appropriate.

The strategies laid out in this blueprint for an organized System of Care are focused on ensuring strong structural supports at the state level in order to assist care system development and ongoing quality improvement within communities. There are recommendations for necessary and critical changes to establish effective structural support. Among these recommendations are:

- **Revising the structure and authority of the Children's Cabinet** as the state level body coordinating the funding systems among all Departments providing services to children and families;

- **Enhancing the Children's Cabinet's lead role in forging collaborative relationships with communities** in order to increase the effectiveness of local strategic planning for services for children, youth and families;

- **Increasing the pool of child and family service practitioners**;

- **Focusing on resource maximization strategies** that recognize that the System of Care requires both public and private resources working together to meet the health, social, emotional, behavioral, mental health and educational needs of children and families;

- **Focusing publicly supported services on priority populations**;

- **Developing community-based Comprehensive Care Networks** to ensure continuity of care and services that are accessible and proximate to the communities in which families live;

- **Developing a planning and evaluation capacity within the Department of Children, Youth and Families**, to track and measure services and treatment to ensure that a child is in the most integrated and least restrictive setting appropriate to the child and to evaluate the outcomes of each setting; and

- **Ensuring public accountability.** The improvement of the System of Care will ultimately hinge on our ability to effectively evaluate program performance and system outcomes, and to use these evaluations to improve practices. It is essential for the Children's Cabinet to strengthen mechanisms to collect data consistently across Departments.

Within the chapters of this report, representatives of the Executive, Legislative and Judicial branches of state government; provider organizations; families; advocates; and public policy

stakeholders have collectively and diligently focused their attention toward the development of an organized System of Care. This document sets forth a comprehensive plan that will allow flexibility and growth as the System of Care continues to evolve to address the changing needs and challenges of children and families in the years ahead.

CHAPTER 1: OVERVIEW

The Rhode Island System of Care for Children, Youth and Families envisioned by the RI System of Care Task Force (Task Force) is built on the strengths of families and communities, the successes of past initiatives, and is responsive to the challenges of the past. It is operationally feasible, financially realistic and supported by broad consensus. This system is a strategic instrument for moving the State closer to the four outcomes embraced by the Rhode Island Children's Cabinet and other key state and community leaders:

- All Children Entering School Ready To Learn

- All Youth Leaving School Ready To Lead Productive Lives

- All Children And Youth Safe In Their Homes, Neighborhoods And Schools

- All Children Living In Families That Are Self-Sufficient, yet Interdependent

This organized, ideal system is defined by the themes that follow and implemented through the identified strategies and processes which support these themes.

THEME: FAMILY CENTERED PRACTICE – A FUNDAMENTAL SHIFT IN SERVICE DELIVERY

This system of care supports the role of the family as the primary caregiver for children and recognizes that the optimum interventions for any individual child and their family are the interventions most proximate to home with the full resources of the community made available to that child and family *(see Chapter 3 and Appendices B and D)*. It is critical to note that "families" include biological parents, adoptive families, extended kinship networks, legal guardians, temporary foster families and other supportive individuals the youth identifies as family. The broad vision is one in which a substantially greater portion of state resources are allocated to universal and selected prevention or early intervention services. However, the system of care acknowledges that substantial portions of the state's limited resources must be focused to meet the immediate needs of identified priority populations.

THEME: PREVENTION AND EDUCATION

The system's foundation is coordinated by local community members and state staff to ensure that all neighborhoods where families live have strong prevention and educational services and supports for the complex and changing needs of today's children and families. It is a system which provides families and other caregivers ready access to the resources necessary to meet children's developmental needs. The system has mechanisms to redirect cost savings from reduced reliance on restrictive and expensive out-of-home placements to community-based prevention and intervention services while ensuring that access to federal and state entitlements for eligible children and their families cannot be restricted or capped. This is accomplished by shifting service delivery methods for these priority populations from a provider-driven, bed-based methodology to a **culturally competent, family centered, gender specific, community-based methodology that is school-linked**, provides adequate state aid to achieve better outcomes, and integrates state and local agency resources *(see Chapter 2)*. Included among these resources are those that meet the basic physical, emotional, developmental and educational needs of all children, as well as special resources to meet the individual needs of children with disabilities and social, emotional, and behavioral

disorders; children who have been abused and/or neglected; youth involved with the juvenile justice system; and system-involved females, whose unique pathways into the system and specialized needs have only recently come into view.

THEME: *PROMOTING BEST PRACTICES*

The Rhode Island System of Care is built upon and builds on principles of best practice. Too often government and private resources have been used to establish and support programs which often show little evidence of significantly increasing positive outcomes for children, youth, and families. This in turn has led to a significant decrease in the resources available to programs and services that provide promising or excellent results through quality outcomes. In order for Rhode Island's System of Care to make effective use of finite resources, it requires all components of the system to follow best practice principles which ensure that each child is served in the most integrated setting appropriate.

SYSTEM STRATEGY #1 - *CHILDREN'S CABINET'S LEAD SYSTEM ROLE*

The Children's Cabinet provides the state leadership necessary to assist each community in organizing new or strengthening existing collaborative efforts aimed at increasing the ability of communities to plan strategically to meet the needs of their children, youth and families *(see Chapter 2)*. Emphasis is placed on rewarding community-wide collaboration through the targeting of technical assistance and funding to communities which have collaboratively developed local strategic plans for enhancing prevention programming and identifying community, strengths, risks, and needs in relation to children and their families across the system of care.

SYSTEM STRATEGY #2- *COMMUNITY OWNERSHIP SUPPORTED BY STATE AID*

In embracing these outcomes, the system is one which recognizes that communities bear the primary responsibility for helping children and families succeed, while ensuring that limited state resources are effectively mobilized to aid communities with this challenge *(see Chapter 2)*. It recognizes that the state bears the primary fiscal responsibility for these services. Built on the concept of **family-centered practice** *(see Appendix B)* **and the principles of the Child and Adolescent Services System Program** *(CASSP; see Appendix D)*, this system recognizes and endorses the belief that the most effective path to success is for communities to take responsibility for - "to own" - all of their children and families, especially those viewed as the most challenging. All facets of the community, especially schools, accept their responsibility in supporting all children and families and ensuring that services are provided either in the community or as proximate to the community as possible. This support is particularly critical when an individual returns from placement outside of the community, including residential programs, psychiatric hospitals, the RI Training School and the Adult Correctional System.

SYSTEM STRATEGY #3 – THE FAMILY COURT AND DCYF: A CRITICAL RELATIONSHIP

In this system, DCYF is the lead agency with the statutory authority[1] and responsibility for developing and managing the system of care and services. DCYF ensures that children, youth, and their families from identified priority populations are provided the care necessary so that these children and youth either remain in their home or are provided a permanent home as quickly as possible within the parameters of effective clinical treatment and public and personal safety. At the same time, the RI Family Court[2] is the branch of government with statutory authority to make determinations regarding state custody of children and youth, permanency issues, and public safety. This system works on the premise that an effective relationship exists between DCYF and the Family Court that emphasizes appropriate health, safety and care issues for children, youth and families.

SYSTEM STRATEGY #4– PROMOTING BEST PRACTICES

The system is geared at all levels to **research based prevention, early intervention, crisis intervention, and family stabilization** in order to provide children and their families the greatest levels of consistency and stability possible. Decisions regarding treatment and services are made on an individual basis according to the strengths, risks, and needs of the family and the best interest of the child with a recognition of available fiscal resources. Methods allow for the blending or collaborative use of various funding streams to benefit the child and family. Each child and family is provided with care that is supported by research and the highest professional standards.   Providers are required and supported to deliver services according to nationally recognized standards with evaluation mechanisms in place to monitor outcomes *(see Chapter 7 and Appendix K)*.

SYSTEM STRATEGY #5 – INCREASING THE POOL OF CHILD AND FAMILY SERVICE PRACTITIONERS

Mechanisms exist to ensure that there is an appropriate supply of paraprofessional caregivers and licensed professionals at all levels and across all disciplines *(see Chapters 4 and 5 and Appendix J)*. The Children's Cabinet works with the Department of Human Services (DHS) as the Medicaid agency to ensure that Medicaid reimbursement rates across state agencies are adequate and consistent to encourage individuals to practice in Rhode Island.   The Department of Health, the Department of Elementary and Secondary Education, and the Office of Higher Education lead the Cabinet's efforts to work with institutions of higher education to train and educate these professionals to work in Rhode Island. State agencies and private providers collaborate to develop and implement policies and practices, including career ladders, which enable the recruitment and retention of highly qualified professionals.

SYSTEM STRATEGY #6 – RESOURCE MAXIMIZATION

In this new Rhode Island System of Care, either private or public health insurance covers all children and their families *(see Chapter 4)*.   Mental health screening for children is a requirement for both Medicaid (EPSDT/SCHIP) and private insurers. When problems are identified, children receive a comprehensive behavioral assessment, evidence-based family centered treatment and effective aftercare services.

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[1]Including RIGL 42-72-5, 42-72-16, 42-72-17, 42-72-18, 42-72-19 and 42-72.1-3.

[2]Including RIGL 8-10-3, 14-1-5, 14-1-11, and 15-7-7.

DCYF works closely with both public and private insurance companies to develop clinical pathways and procedures for cost sharing when necessary. The system of care builds on the success Rhode Island has achieved in maximizing access for children to healthcare. The Department of Human Services (DHS) continues to work with community partners and other state agencies to improve care and services for eligible children and maximize Medicaid reimbursement. Access to Medicaid-reimbursable services for children with special health care needs is enhanced through the expanded use of CEDARR Family Centers and the collaboration of CEDARR Family Centers with DCYF's Care Networks and the LCC structure. The Department of Health (DOH), in collaboration with other state agencies, works with private health care insurers to extend benefits for children with special health care needs to assure access to quality screening, assessment, and all levels of medically necessary care for children.

DCYF STRATEGY #1 - LEAD ROLE WITH PRIORITY POPULATIONS

This system recognizes, embraces, and supports the statutorily defined lead role delegated to the Department of Children, Youth and Families "to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential."[3] DCYF, in collaboration with Children's Cabinet agencies, ensures that a full array of services is available to all children and their families. DCYF focuses its resources on three priority populations, recognizing that a majority of the concentration of these populations are found in Rhode Island's six core cities[4]. These populations are:

❑ Dependent, neglected or abused children and youth **requiring state intervention to ensure safety;**

❑ Children and youth who meet clearly defined criteria for Serious Emotional Disturbance or Developmental Disability **and who require publicly supported care and services; and**

❑ Youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

DCYF STRATEGY #2 – REGIONALLY ADMINISTERED AND INTEGRATED CARE AND CASE MANAGEMENT

DCYF integrates the day-to-day operation of juvenile corrections, children's behavioral health, and child welfare *(see Chapter 3).* Regional Offices coordinate all child welfare[5], behavioral health, and juvenile corrections services through the lens of **family-centered, culturally competent**, gender specific *(see Appendices B, C and L)* practice that is **community-based and school-linked**. DCYF strengthens the authority and responsibility of

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[3]RIGL 42-72-5(a)

[4] These are originally identified as Central Falls, Newport, Pawtucket, Providence and Woonsocket in the 2001 Rhode Island KIDS COUNT Factbook. Providence: Rhode Island KIDS COUNT, p. 3. Based on new census data, KIDS Count has recently added West Warwick to their list of core cities.

[5] Child Protective Services, including the child abuse hotline, investigative functions and intake remain Central Office functions

the four Regional Offices and the Rhode Island Training School for Youth (Training School), shifting to these locations day-to-day operational decisions with the requisite budgetary authority and responsibility. This shifts the focus of the Central Office to providing greater administrative support and oversight, technical assistance, and specialized resources to the Regional Directors and their staff. In so doing, DCYF does not seek to replicate new positions in each of the four Regional Offices but seeks rather to re-task existing functions within the Department.

DCYF STRATEGY #3 – COMMUNITY-BASED COMPREHENSIVE CARE NETWORKS

Working in partnership with families and community leaders in their region, Regional Directors lead DCYF's efforts to create Comprehensive Care Networks with lead agencies responsible for the provision and management of an array of services *(see Chapter 2 and Appendices G and H)* with the capacity to meet the needs of targeted populations within their respective region and to assess and monitor whether each child is placed in the most appropriate integrated setting   DCYF Central Office, through the Children's Services Research and Planning Center (CSRPC) and additional administrative support resources (i.e., program development, billing and reimbursement systems, utilization review), provides analytical, clinical and other technical support to the Regional Directors and communities to accomplish this task. These Comprehensive Care Networks are DCYF's primary partner with DCYF social caseworkers and probation counselors for delivering direct care services within each region. The Comprehensive Care Networks are responsible for describing specific areas where they integrate with local schools and implementing interagency agreements as described in the Rhode Island Student Investment Initiative.

DCYF STRATEGY #4 - CHILDREN'S SERVICES RESEARCH AND PLANNING CENTER (CSRPC)

DCYF management and decision-making structure is supported by the Children's Services Research and Planning Center (CSRPC) *(see Chapter 2).* This Center reports to DCYF Director, is composed of a small centralized group of DCYF staff and external researchers, and focuses on management planning, research, and evaluation. This group supports the Director, Senior Executive Team, and Regional Directors by completing management, planning, and analysis tasks that continuously assess and improve the care and services within the System of Care delivered by and through DCYF, including the development and implementation of performance measures and strategic plans.   These measures include collecting and reviewing data regarding whether each child is in the most integrated setting appropriate and, for each child who is not in such a setting, evaluating whether there is a plan to move each such child to such a setting at a reasonable pace. The Center works in collaboration with other state and private agencies to ensure effective cross-disciplinary planning.

PUBLIC ACCOUNTABILITY PROCESS #1 - OUTCOMES, INDICATORS AND PERFORMANCE MEASURES

Key to the success of the system of care is the ability to effectively evaluate performance and outcomes and to use these evaluations to improve practices *(see Chapter 6 and Appendix K).* The system is accountable through context evaluations, implementation evaluations, and outcome evaluations. The Children's Cabinet establishes system-wide outcomes and key social indicators. DCYF develops performance measures for DCYF and its Care Networks.

The indicators and measures are aligned with and logically linked to the four Children's Cabinet outcomes. The system places high value on the four Children's Cabinet outcomes and routinely measures and reports on key social indicators and individual program performance measures.

PUBLIC ACCOUNTABILITY PROCESS #2 - IMPLEMENTATION TIMELINE

The plan that follows is intended to be implemented over the next <u>five years</u> while ensuring stability for children and families and causing as few disruptions to services as possible *(see Chapter 7).* The success of the system of care is dependent on the ability of all key stakeholders to collaborate. Success is measured in terms of:

❏ positive changes in outcomes for children and families,

❏ customer satisfaction, and

❏ the ability of the system to complete identified tasks and meet prescribed milestones within predetermined time frames.

Stakeholders in the system commit to this collaborative process and identify clear timelines for progress, evaluation, reporting, and adaptation.

CHAPTER 2: COMMUNITY-STATE PREVENTION PARTNERSHIPS/ROLE OF THE CHILDREN'S CABINET

Families and Community and State Leaders clearly recognize the important role prevention services play in the system of care and in supporting children, youth, and families for success. The promotion of emotional and physical health is a key responsibility of the Children's Cabinet in partnership with local communities. The system's foundation is the commitment of local communities and the State to ensuring that all neighborhoods have strong prevention and educational services to support the complex needs of their children and families. The Children's Cabinet provides leadership in regard to the structures and mechanisms by which collaboration among state agencies is explicitly described and implemented, including dedicating personnel and other resources.

The principles of **family-centered,** *(see Appendix B)* **culturally competent** *(see Appendix C)* and gender-specific *(see Appendix N)* practice are embedded values in the system of care's community-based prevention services. The system ensures that families and the multiple cultural, linguistic and religious groups that make up the community are viewed as valuable and equal partners at all levels of development, implementation and service delivery. Built upon CASSP principles *(see Appendix D)*, this system ensures that decisions regarding treatment and care are made on an individual basis according to the strengths, risks, and needs of families and the best interest of the child with a recognition of available fiscal resources and that children and youth are placed in the most integrated setting appropriate.

Rhode Island's System of Care understands the role it plays in promoting the mental health of children as defined by the US Surgeon General[6]. It is a system geared at all levels to the earliest possible intervention, prevention, crisis intervention, and family stabilization in order to provide children with the greatest opportunities to achieve and maintain good mental health. It has the capacity to provide services to all children and families at the level[7,8] of

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[6] "Spanning roughly 20 years, childhood and adolescence are marked by dramatic changes in physical, cognitive, and social-emotional skills and capacities. Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills (Surgeon General's Report, 2000, p.123)".

[7] The MECA study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents) estimated that [nationwide] almost 21 percent of US children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (Surgeon General's Report, 2000, p.123)". Eleven percent of youth have significant functional impairment. This estimate translates into a total of 4 million youth who suffer from a major mental illness that results in significant impairments at home, at school and with peers and five percent are classified with extreme functional impairment (Surgeon General's Report, 2000, p.124).

[8] The foremost finding in the Surgeon General's report is that [nationwide] most children in need of mental health services do not get them (p. 180). The conclusion that a high proportion of young people with a diagnosable mental disorder do not receive any mental health service at all (Burns, et al., 1995; Leaf et al., 1996) reinforces an earlier report by the US Office of Technology Assessment (1986) which indicated that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services. Only one in five children with a serious emotional disturbance used mental health specialty services although twice as many such children received some form of mental health intervention (Burns et al, 1995). Thus, about 75 to 80 percent fail to receive specialty services, and the majority of these fail to receive any services at all, as reported by their families (Surgeon General's Report, 2000, p180)"

prevention or intervention they need while focusing on supporting and maintaining children and youth in their home or as proximate to their home as possible.

Service needs are identified, developed, and implemented across all three levels of the prevention continuum:

❑ **Universal Prevention Services:** Evidence-based services designed to be accessible to all children and families regardless of their level of need with the intended outcome of reducing the number of children and families requiring higher levels of services. Examples include wellness educational campaigns, child abuse prevention media campaigns, emotional competency programs with children, out-of-school time programs, general recreational programs, mentoring programs, teen pregnancy prevention programs, drug and alcohol abuse education programs, and domestic violence prevention programs.

❑ **Selected Prevention Services:** Evidence-based services designed to address factors that hamper the abilities of families to appropriately foster their children's development and ensure that families have access to the resources that are necessary to meet their children's developmental needs. Examples of these include parent education programs, family resource and support programs, counseling, parent aide programs, home visiting programs, wraparound and non-traditional services, therapeutic recreation programs, mentoring programs, school-based health clinics and prevention education for youth, parents and professionals.

❑ **Indicated Prevention Services:** Evidence-based services designed to address the needs of families and children with special health care needs as well as those exhibiting indicators known to be high predictors for teen pregnancy, early drug and alcohol use and/or abuse, witnesses to or victims of domestic violence, child abuse or neglect, and juvenile delinquency. Examples of these include early intervention services for young children, counseling, parent education programs, parent aid programs, home visiting programs, therapeutic daycare, school-based mental health support teams, wraparound and non-traditional services, teen pregnancy prevention programs, drug and alcohol abuse education programs, in-home services for children with special health care needs, mentoring programs, domestic violence prevention programs, and juvenile hearing boards.

The reality of the current system is very different. Fragmentation of the service delivery system frequently leads to prevention planning and programming being developed and conducted within silos. Multiple funding streams with unaligned priorities from multiple agencies lead to overlap, redundancy, and sometimes competing goals.   There is little coordination at the local or state levels in regard to prevention planning and service delivery. The System of Care envisioned by the Task Force remedies this by ensuring that indicated prevention services are targeted and funded locally by DCYF and other state agencies through Care *Networks (see Chapter 3).* Universal and selected prevention services are coordinated by the Children's Cabinet and local communities with funding from federal, state, and local sources.

COMMUNITY/STATE PARTNERSHIP S RECOMMENDATIONS

In this system, the Executive, Legislative, and Judicial branches of government collaborate to eliminate this fragmentation, shift responsibility for children and families to the community level, and ensure that communities are given the requisite fiscal and technical resources to be able to "take ownership" of their children and families.

In order for the State to support strategic planning and local prevention service delivery, the following recommendations are made:

1. **$ The Children's Cabinet must actively work with families and community leaders to strengthen existing or organize new local, collaborative strategic planning efforts aimed developing, implementing, and measuring the results of strategic plans for enhancing prevention programming and identifying the needs of the their community in relation to children and families across the system of care** *(see Appendix E).*

   Significant progress has been made in the area of developing and supporting collaborative entities in the five core communities through DCYF-administered *Comprehensive Strategy Initiative for Serious, Violent and Chronic Juvenile Offender.* Community planning teams exist in each of the five core cities. These teams are representative of the stakeholders identified above and have successfully completed five-year strategic plans aimed at reducing juvenile violence and delinquency by supporting strong prevention and intervention programming from birth to young adulthood. Each of the *Comprehensive Strategy Planning Teams* are supported by the mayor of their respective city or town.

   With limited financial support from the state for coordination, they have used their coalitions to garner significant federal and state funds to operate youth employment programs, reading readiness programs for school-age children, mentoring programs, domestic violence awareness programs, and other services. The coordinators of these teams have played an integral role in the work of the *Youth Success Cluster* of the Children's Cabinet, a state level collaboration focused on infusing a youth development philosophy within state and local initiatives and programs.

   Other examples of effective local partnerships have been the Local Coordinating Councils for Children's Behavioral Health (LCC's) and the local Substance Abuse Prevention Task Forces. Though it varies from community to community, each of these groups have been highly effective in breaking down the barriers among local agencies and finding ways to cooperatively identify resources to be used to benefit the community as a whole, rather than to build the programs and services of a particular agency.

   The Children's Cabinet must focus attention on identifying with communities such partnerships and on how to build on these partnerships to enhance prevention planning and service delivery.

2. **$ The Children's Cabinet must develop a permanent state staff level subcommittee to develop and coordinate prevention planning among state agencies and ensure that this subcommittee is provided the resources necessary to succeed. This subcommittee will be viewed as the state's key link to communities and will be required to ensure community participation in their deliberations and decision-**

making process.   It will be responsible for assisting communities with identifying research-based programs and services, coordinating funding streams, developing program outcomes and measurements, and evaluating the success of state and community efforts in the area of prevention.

Many stakeholders have advocated for a formal mechanism by which families, providers, and advocates can present regular feedback on how the system as a whole and the various sub-components are operating and to gather feedback on ideas to increase the system's effectiveness. The Prevention Planning Subcommittee will serve this purpose. It will also serve as the principal forum for planning and implementing statewide universal and selected prevention initiatives.

In order to implement this recommendation, the Children's Cabinet must review its current committee structure with a focus on merging committees which have similar missions and responsibilities. For example, the Youth Success Cluster, in existence for four years, has been successful at moving forward on issues such as youth employment, reducing juvenile delinquency, and out-of school time programming with a youth development focus. The Children's Cabinet also recently endorsed a new subcommittee, the Statewide Prevention Planning Committee, in response to the State applying for and receiving the State Incentive Grant Award from the Center for Substance Abuse Programs (CSAP) of the US Department of Health and Human Services (DHHS). Rather than attempt to support the work of multiple subcommittees which may often be duplicative, the Cabinet must review them and determine the most effective subcommittee structure for the future.

Given DCYF's designation as the state agency principally responsible for the implementation of the recommendations of this report, it is reasonable that DCYF be called upon to administer prevention planning and implementation for the Children's Cabinet in collaboration with its sister state agencies.

3. $ **The Children's Cabinet agencies, through the Prevention Planning Subcommittee, must review the State's prevention funding streams with the goal of blending funding as permissible under state and federal guidelines and increasing the level of collaboration in regard to funding decision-making.**

There currently exists numerous funding streams managed within multiple departments that are principally and sometimes solely focused on prevention activities. Examples include the Safe and Drug Free Schools Program and the Healthy Kids, Healthy School Program administered by the RI Department of Education (RIDE); child abuse prevention funding administered by DCYF's Children's Trust Fund; underage drinking prevention and the new State Incentive Grant Program administered by the RI Department of Mental Health, Retardation and Hospitals (MHRH); teen pregnancy prevention administered by the RI Department of Health (DOH); and juvenile delinquency prevention administered by the RI Department of Administration's (DOA) RI Justice Commission (RIJC).

Although efforts have been made to increase the level of blending of these funds as permitted by state and federal laws and regulations or to increase the level of collaboration in decision-making processes, much more progress must be made in this area. The Prevention Planning Subcommittee of the Children's Cabinet is an ideal venue for further analysis and the development of a collaborative plan.

4. $ 🗒 **The Children's Cabinet must develop and implement a plan which provides for greater information sharing and collaborative decision-making among agencies, especially DCYF, DHS, RIDE, MHRH, DOH, the Judicial Branch, DOC, the Attorney General, the Public Defender, and Law Enforcement.**

The Children's Cabinet recognizes the value of increasing the capacity for information to be shared across agencies in accordance with state and federal laws. The lack of this capacity hampers the State's ability to identify and track service use patterns, arrest and recidivism patterns, service gaps, and other key indicators. The Cabinet has created an interagency workgroup, the KIDSLink Project, to begin to develop such an information sharing plan. This effort must be fully supported by key stakeholders at all levels. This capacity will permit agencies to more effectively communicate with one another, see where services overlap, track recidivism, identify existing gaps, and analyze some of the global budget implications for the children and families served. In developing such an interface, the State must make every effort to protect and ensure the confidentiality of individuals by building in appropriate safeguards.

5. $ **The Children's Cabinet must support a statewide Information and Referral System that is consistent across departments and may be accessed by youth, parents, other supportive adults, and children's services professionals. This system will have up-to-date computerized information on access to and performance of children's prevention and treatment services, related state and federal laws, entitlements, regulations, eligibility, and admissions' processes.   Information will be available in several languages, in alternative accessible formats, and be accessible by phone, Internet, and fax.**

Prevention and treatment programming cannot be utilized effectively if the individuals who need the services do not know about them. This information and referral service will provide children, youth, families, and professionals with the access they need to obtain current information on services, legal rights, and other information.

6. $ **DCYF, RIDE and DHS must immediately implement the agreed upon "Coordinated Children's Services System Regulations" (the "pilot" regulations) while ensuring that access to federal and state entitlements for eligible children and their families cannot be restricted or capped.**

These regulations, developed as required by RIGL 42-72.7, allow for a process which accomplishes two major goals:

To improve collaborative planning, comprehensive services, and outcomes for children with complex special needs and their families;

To establish a new system of service funding that utilizes current state level funding but establishes a funding system that provides for locally determined and family centered decision-making about the best utilization of that funding for locally-based residential treatment services and wraparound services as an alternative to out-of-region or out-of-state residential treatment services for children in the pilot catchment areas of Pawtucket/Central Falls and Washington County.

This funding mechanism provides participating LCC's with blended funding from various state agencies and Local Education Agencies (LEA's) equal to the amount each agency currently invests in an identified child's residential treatment.   These funds are designed to provide maximum flexibility to purchase services based on the strengths and needs of children in need of education, care, and treatment and their families and ensure that services to children and youth are provided in the most integrated setting possible.

DCYF, RIDE, DHS, and other state and community stakeholders have collaborated to develop these regulations over the past three years.   These regulations address agency responsibilities and coordination and also provide resolution mechanisms.   The opportunity to implement these pilot projects dramatically align with the State's commitment to system-wide reform. This implementation process must be monitored and evaluated by the participating departments to inform the development of the Comprehensive Care Networks.

CHAPTER 3: STRENGTHENING DCYF AS A FAMILY CENTERED, REGIONALLY-BASED AGENCY

As previously indicated, DCYF is the state agency responsible for leading this "paradigm-shift" to **a system of care that is family centered, culturally competent, gender specific, and school-linked, and community-driven**. It is DCYF's responsibility to ensure that the limited state fiscal resources available to support and sustain this system are utilized more effectively than in the past with an emphasis on priority populations[9].

This shift recognizes that the current system is too fragmented, inhibiting the growth of a strong community-driven system. Currently, DCYF is expected to provide services to much broader sectors of the population than is realistic. Contracted programs are generally statewide in nature with at best weak links back to the child/youth/family's community. Programs are frequently filled to capacity or above leading to:

❑ unnecessarily long lengths of stay,

❑ the placement of children and youth on a night-to-night basis until a permanent placement is made,

❑ "waiting lists" which frequently lead to children and youth symptoms escalating to a point where psychiatric hospitalization is needed, and

❑ a dependency on expensive out-of-state purchase of service (POS) placements which often greatly reduce effective family involvement.

It is recognized that DCYF cannot and should not move abruptly to a system which significantly disrupts current practices. Such a sudden change in service delivery methods would have disastrous implications to the quality and quantity of services available for targeted populations. In the short-term, this will require DCYF to continue to contract with individual providers for a specific number of beds or slots. During this transition, DCYF must make prudent use of in-state and out-of-state Purchase of Service providers. However, it is imperative that DCYF continue to move forward with their efforts to create a true "paradigm-shift" to a **family-centered, culturally competent, gender-specific and regionallybased service delivery system**. The full transition must occur in a well-planned, well-coordinated fashion with reasonable haste being balanced by prudent decision-making that is least disruptive to children, youth, and families. During this transition time, DCYF will assess all children with behavioral health needs who are not in their family homes and determine whether each child is in the most integrated setting appropriate. For those children who could be in a more integrated setting, DCYF will move these children at a reasonable pace to the most integrated setting appropriate. In order to accomplish this, DCYF may need to expand or expand funding to existing services or programs and/or create or fund new services or programs to do so.

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[9] Dependent, neglected or abused children and youth **requiring state intervention to ensure safety; c**hildren and youth who meet clearly defined criteria for Serious Emotional Disturbance or Developmental Disability **and who require publicly supported care and services;** and youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

DCYF has made significant inroads over the past five years into moving the agency structure and the service delivery methods to a more family-centered, regionally-based structure. Each of the four family service regions have physically relocated to offices within their respective service areas *(see Appendix F)*. The Local Coordinating Councils' for Children's Behavioral Health (LCC's) have shown significant success in helping families to receive and agencies to provide family-centered, community-based services for many years.[10] The Review Team process for children with high-intensity service needs is being moved into the regions with full community partnership in the design of the Care Management Team (CMT). DCYF has merged individual program contracts with the eight Community Mental Health Centers (CMHC's) into one master contract for each CMHC. A pilot Care Network was implemented for 60 youth in need of residential placement and early results are promising. Placement Solutions, a collaboration between the Providence Center and Communities for People, is providing much needed utilization review capacity for children and youth in out-of-state and in-state placements. Working in conjunction with DCYF's Child By Child Project, the immediate goal of this effort is to move these children and youth back to their home communities with necessary supports as soon as it is clinically appropriate. Finally, Project Hope is working with RI Training School staff, families and their communities to reintegrate children from the Training School directly back into their neighborhoods.

STRENGTHENING DCYF AS A FAMILY CENTERED, REGIONALLY-BASED AGENCY RECOMMENDATIONS

Even with this progress, deeper structural and process changes must be made. To accomplish this, DCYF must be supported by state leaders, advocates, providers, family members and other key stakeholders in their efforts to further uphold an agency that is family centered and regionally-based. To this end, the following recommendations are made:

1. **DCYF must continue to move toward a structure which supports a family centered, community-based, culturally competent, gender-specific and school-linked approach. To effectively manage this structure, DCYF must provide regional directors and juvenile corrections administrators with greater authority to manage staff and resources, including fiscal and program resources.**

    A. **$ Regional Directors and the Training School Superintendent will be provided with concrete regional budgets and the concomitant responsibility and authority for managing these budgets;**

    B. **$ DCYF should expand the use of the Care Network Model** *(see Appendices G and H)* **to ensure that the majority of services to the targeted population groups[11] are provided by regionally-based Comprehensive Care Networks that are contracted through specified lead agencies;**

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[10] See Kaufman, J.S., Tebes, J.K., Ross, E. & Grabarek, C. (2000) Project REACH Rhode Island Final Evaluation Report. New Haven, CT: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, the Connecticut Mental Health Center and The Community Consultation Board, Inc.

[11] Dependent, neglected or abused children and youth **requiring state intervention to ensure safety; c**hildren

C. **Regional Directors and their staff will be expected to work with Comprehensive Care Network lead agencies, lead agency subcontractors, and other key community stakeholders to ensure that services provided by Regional Staff are family-centered, community-based, culturally competent, gender-specific and linguistically appropriate.**

Best practice standards across all three population domains served by DCYF call for social caseworkers, probation counselors, behavioral health practitioners, and other state agency staff to develop linkages and more effective collaborations with families and key stakeholders in the communities they serve. DCYF has developed or assisted communities in developing several initiatives aimed at increasing these linkages and levels of collaboration. These include the *Child and Adolescent Service System Program(CASSP) for Children's Behavioral Health* which functions through the *LCC's*, the *Project Hope* program focused on enhancing transition and aftercare services for youth identified as seriously emotionally disturbed who are transitioning from the Training School, the *Youth New Futures* program which provides services to high-risk youth on probation through an interagency collaborative of providers[12], and the *Safe Streets[13]* program. Strengthening and providing increased supports to the four DCYF Family Service Regions and juvenile corrections administrators will enhance the ability of these locations to work more effectively and collaboratively in the communities they serve.

2. **DCYF must continue to develop a family centered practice model and to ensure that older youth without clearly identified families are provided the supports and services they need to succeed.**

DCYF has made significant strides in moving the agency to a service delivery model based on the principles of family-centered practice *(see Appendix B).* DCYF is strongly encouraged to continue these efforts internally and with external stakeholders.

The Department has also made significant strides over the past few years in enhancing efforts aimed at preparing older youth for independence and self-sufficiency. Through the Chafee Foster Care and Independence Program, youth who are age 16 or older receive life skills training and preparation for their transition out of care. Additionally, through our legislative initiative, older DCYF involved youth are afforded opportunities for higher education through the Community College of Rhode Island, Rhode Island College and the University of Rhode Island. The Department's policies

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and youth who meet clearly defined criteria for Serious Emotional Disturbance or Developmental Disability **and who require publicly supported care and services;** and youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

[12] *Youth New Futures*, funded through DCYF, is a collaboration of Tides Family Services, the John Hope Settlement House and DAWN for Children. This program currently provides services only to youth from Providence and Pawtucket.

[13] *Safe Streets* currently operates only in the city of Providence and is a collaborative effort between DCYF's Division of Juvenile Corrections' Juvenile Probation Units, the Department of Corrections' Adult Probation Office and the Providence Police Department. Juvenile and Adult Probation Counselors, working under the joint supervision of the two state agencies, join with Providence Police officers to provide intensive supervision services to very high-risk young adult offenders ages 16-24. Average caseloads are 15:1.

and procedures relating to Independent Living focus great attention on transition efforts to assist youth in out-of-home placement, ages 16 and above, to become self-sufficient as they prepare for adulthood. This preparation includes departmental staff, family and/or primary caregivers and other individuals involved in the care and treatment of the youth.

However, it is recognized that youth who are aging out of DCYF services often do not have a significant biological family connection and there is a growing awareness that important connections for these youth must be cultivated to assist with their transition from DCYF care. As part of its Family Centered Practice implementation and training, the Department will focus more attention on ways in which youth may be assisted in identifying and making valuable connections to caring individuals who will be an important and necessary support for them ongoing.

3. **DCYF must continue to expand efforts toward developing cultural competence among agency staff and vendors.**

DCYF has also made significant strides over the past two years in developing within the agency a stronger atmosphere of culturally competent *practice (see Appendix C)*. However, the agency recognizes and understands that there is still much progress to be made and that achieving cultural competency is a journey, not a destination. DCYF is strongly encouraged to continue on this journey.

4. **DCYF must continue to expand efforts toward developing gender-specific programs and gender competent staff among agency staff and vendors.**

DCYF is beginning to make significant strides in moving the agency to a service delivery model based on the principles of gender-specific programming for females *(See Appendix N)*. The Task Force strongly encourages DCYF to continue these efforts internally and with external stakeholders. While gender-specific programming applies to specialized programming for either gender group, the Department's current focus is on gender-specific programming for females because females' involvement in the juvenile justice system has been increasing and program models and intervention modalities have been geared toward the needs of a predominantly male population. Specifically, in collaboration with the Rhode Island Justice Commission (RIJC), DCYF is working to develop a stronger culture of gender specific practice at the Training School and provide preliminary assessments of contracted programs. DCYF recognizes, however, that cultural change occurs over time and with sustained effort. DCYF has created the *Advisory Committee on Effective Programming for Young Women in Rhode Island* to spearhead this effort. There is still much progress to be made, as well as a need to begin a DCYF-wide initiative to enhance gender competency among internal and external staff and providers and to develop and implement gender-specific programming for females.

5. $ **DCYF must provide the Regional Offices and Comprehensive Care Networks with the administrative support services necessary for them to succeed.**

An essential management component for the system of care is the capacity within DCYF to effectively support the Regional Offices with their responsibility to administer and manage the Comprehensive Care Networks. This capacity includes expanded **analytic, financial, and information management resources for DCYF.** This administrative support function lies within DCYF Central Office but ensures support to each DCYF region It works most closely with the management, budget, and planning and analysis staff, and incorporates DCYF's utilization review

6. $ **DCYF must enhance its research, analysis, and planning capacity to support the system of care through the development of the Children's Services Research and Planning Center (CSRPC).**

The Children's Services Research and Planning Center (CSRPC) is composed of a small, centralized group of DCYF staff and external researchers focused on management planning and analysis. This Center works in collaboration with other state agencies to ensure effective interagency planning. This group reports to DCYF Director. Analysts have demonstrated competence in both data analysis and the clear presentation of complex information. They minimally possess masters' degrees in fields such as public administration, business administration, social work, social policy, and evaluation to ensure that they have the proper training to conduct analyses and think creatively about structure and process improvement.

This group supports the Director, Senior Executive Team, and Regional Directors by completing management, planning, and analysis tasks that continuously assess and improve the system of care, including the management of performance measures and strategic plans. The CSRPC coordinates the following activities:

❑ Analysis of children, youth, and families' service needs by geographic location

❑ Mapping current capacity and usage by location

❑ Developing common regional boundaries for all divisions of DCYF including Child Welfare, Children's Behavioral Health, and Juvenile Corrections that are mapped to the CPP's, CMHC's, LCC's, LEA's, Comprehensive Strategy Planning Teams, and other key players

❑ Developing and managing a strategic planning process for the Department to implement the design recommendations contained in this report

❑ Developing and managing a set of management performance measures to help DCYF monitor and report on progress against established targets and to provide an early warning system for problems

❑ Analyzing the existing budget to develop regional budgets which are adjusted so that the areas of the state where the need is greatest are targeted with service dollars and resources

❑ Developing RFP's and certification standards for regional lead agencies

This internal analytic capacity provides the data necessary to target services and resources, measure outcomes, and lead improvements. These measures include collecting and reviewing data regarding whether each child is in the most integrated setting appropriate and, for each child who is not in such a setting, evaluating whether there is a plan to move each such child to such a setting at a reasonable pace. The CSRPC is the Senior Executive Team's resource for validating information and anecdotal reports and supports their ability to consistently focus on strategic plan implementation and performance indicators in the face of a daily barrage of unanticipated events. This office is invaluable to central office and regional managers alike.

7. **DCYF should continue its efforts to reform the RI Training School through the construction of a new facility, the implementation of the Resocialization Model, the implementation of gender-specific programming for females, and the finalization and implementation of a sentencing and sanctioning advisory process for DCYF to provide the Family Court with more individual and specific assessments and recommendations.**

Each of these reform components except for the construction of the new facility and the implementation of gender-specific programming were identified as recommendations in the report of the Governor's Task Force on Juvenile Justice Reform[14]. The construction of the new facility is supported by the Governor and the General Assembly provided its' support through the passage of 2001-R-340 Joint Resolution Approving The Financing Of A New Training School For Youth At The Pastore Center In Cranston. DCYF is finalizing work with the National Council on Crime and Delinquency (NCCD) in regard to the development of risk assessment and structured decision-making tools which will allow DCYF to provide more informed recommendations to the Family Court in regard to sentencing decisions. DCYF is also entering into a contract with the Texas Youth Commission in regard to implementing the Resocialization Model at the Training School. The Resocialization Model provides state of the art assessments of strengths, risks, and needs of juvenile offenders with case plans that emphasize personal responsibility, increase freedom in phases based on achieving individualized measurable goals and objectives, holds youthful offenders accountable for their offenses, and requires youth to demonstrate sustained competencies.

Finally, DCYF is collaborating with the RIJC through a contract with Core Associates to assess the level of gender-specific programming for females at the Young Women's Unit and recommend enhancements; develop and implement comprehensive staff training in regard to gender-specific practice; and guide essential program development for female residents

$ **State leaders should support the plan provided by DCYF to the Joint Legislative Commission to Study an Enhanced Role for Probation and Parole**

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[14] Stopping Youth Violence: Rhode Island's Response to the Crisis Facing Our Youth: Final Report, (July 1997). Providence, RI: Department of Children, Youth and Families. See Recommendation 1, Strategy 1 p. 19; Recommendation 1, Strategy 2, p. 20; Recommendation 1, Strategy 3, p. 20; and Recommendation 3, Strategy 1, p. 27; Recommendation 3, Strategy 2, p. 28.

(March 13, 2001; See Appendix I) **which calls for a shift to a community supervision model for juvenile probation, the expansion of community support services, the enhancement of early intervention and transitional services for young women offenders in accordance with empirical research on the unique needs of court-involved females and best practices in gender-specific programming, enhanced recruitment efforts for minority probation counselors, enhanced training requirements for probation staff, and lower caseloads.**

DCYF recognizes that the juvenile probation counselors have much greater opportunity for providing community-based services to youth on probation than do adult probation counselors. DCYF also recognizes that juvenile probation caseloads are much lower than adult probation caseloads[15]. However, best practice standards for juvenile probation call for a shift to non-standard hours, increased community supervision and support, smaller caseloads, and better training (including training on how to work effectively with female clients). DCYF believes that the recommendations submitted *(see Appendix I)* to the Joint Legislative Commission to Study an Enhanced Role for Probation and Parole in March 2001 are necessary for DCYF to make this necessary shift.

9. **State leaders must continue to support DCYF in working with community leaders to site new and expand existing residential programs in RI communities.**

It is well known that DCYF has historically depended on out-of-state purchase of service residential programs for youth with specialized treatment needs such as sexual offending or non-hospital residential psychiatric and/or behavioral treatment. This practice is of high cost to the state and reduces the ability of DCYF to engage families and the community in treatment and transition processes.

It is imperative that DCYF have the ability to develop and implement residential programs within RI regions if DCYF is to truly move to a family-centered, community-based model. However, DCYF, as do other state agencies, frequently runs into the barrier of "not-in-my-backyard" attitudes from local communities when attempting to site new programs. DCYF response must have the active support of key leaders throughout state government and within local communities when attempting to site new programs in the future.

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[15]The highest probation caseloads for juvenile probation counselors may average about 41:1 while the adult probation caseloads can be as high or higher than 300:1.

10.   **The Director of DCYF and the Chief Judge of the Family Court must continue to forge and maintain an effective, collaborative relationship between the Department and the Court.**

Recent progress has been made in this area between the Family Court and DCYF. The Court and DCYF have agreed to create a formalized group comprised of members of each agency to address mutual concerns in a prompt fashion. An agreement has been signed in response to FY 2002 State Budget Article 23 by which DCYF and the Family Court developed an agreement clearly outlining the process to be used in making determinations for children and youth for "high-end" placement. Such collaborations need to continue.

CHAPTER 4: FINANCING THE SYSTEM OF CARE

Financing a comprehensive system of care for children, adolescents, and their families is one of the most complex aspects of system reform. Funding for services for children and families comes from a very broad range of federal, state, local, and private sector sources. In FY 2001 DCYF budget exceeded $200 million and these funds were augmented from a number of other sources including but not limited to public and private insurance, federal government grants and contracts, federal entitlements, state general funds, trust funds or other set-asides, and local revenues.

On a State level, funding and supports were available from DHS in the form of RIte Care capitation, fee for service Medicaid claims, and a variety of supports available under TANF. DHS funding for programs for Families and Children in Medicaid alone exceeded $300 million in FY 2001 and covered 120,000 family members of whom over 80,000 were children. LEAs also were a resource available for this system, particularly in their growing role as Medicaid providers.

In this system of care, DHS and DCYF have a strong partnership. DCYF is responsible for developing programs and services to meet the needs of its priority populations. DHS is the designated single state agency with responsibility and accountability for the Medicaid State Children's Health Insurance (SCHIP) programs. The majority of DCYF children, youth, and families are Medicaid/SCHIP eligible. Therefore, the opportunity exists to strategically leverage DCYF's and DHS's authorities and resources to expand services. DHS is a funder with a voice in program development. The responsibility for funding programs is accompanied by participation in design, development, and measurement of program effectiveness. Likewise, in this system, DHS does not establish programs that directly affect DCYF children and families without DCYF's full and equal participation. These two departments operate as a strategic alliance.

The DHS plays an important role in partnering with DCYF and other state agencies to maximize Medicaid support for eligible children and their families. They continue their work with DCYF in developing opportunities for access to RiteCare coverage and their work with DCYF and other state agencies developing opportunities for increased access to services through programs like CEDARR[16] and the LCC's. In this system, DHS ensures access to the full range of medically necessary prevention and treatment services through contractual language with RIteCare providers. DCYF funds provide non-Medicaid reimbursable services. In the system design, the case rate supports the non-Medicaid reimbursable costs while the Comprehensive Care Networks' lead agencies bill Medicaid for reimbursable services with DCYF providing the State Medicaid share.

For non-insurance government funding, the system creates a "state child and family budget" that includes all non-insurance sources of federal and state revenue, clearly organizes the resources to support the system, and recognizes that entitlement programs cannot be capitated. The Child and Family Budget also reflects Federal grants to communities. The system places an emphasis on attracting federal funds, maximizing federal financial

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[16] CEDARR stands for Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation and is a collaborative effort of the following state agencies: DHS, DCYF, RIDE, DOH, and MHRH. DHS administers the CEDARR program.

participation, and creating a comprehensive child and family budget coordinating services across all of these policy domains. These federal funds are augmented by a number of state budget appropriations, themselves scattered across a number of state agencies.

A coordinated and organized system of care requires a deliberate ongoing financial strategy that supports the multiple and changing needs of children, adolescents, and their families, and the changing landscape of service opportunities available within the community of professional practice. The goals of the strategy are to marshal every resource available for the care and treatment of the child and family, private and public, across all funds and programs, to assure access to services and treatment and to use data to inform policy, program, and budgetary decisions within an overall strategy.

The principles of a successful financing strategy include:

❑ Programs and services within a coordinated system must be designed to support the needs of children and families rather than designed to fit the requirements of funding sources;

❑ The potential gain of maximizing financing from any single source of revenue must be evaluated in light of its impact on program and service delivery, system design, and accountability, as well as overall financial risk;

❑ The ongoing success (and therefore funding) of programs and services must be based on the outcomes they produce, rather than the activity they perform;

❑ Rates of payment must be adequate to create and maintain service capacity and rationalized in terms of the value they provide; incentives must support the long term outcomes desired for the system as a whole; and

❑ Formal and dynamic partnerships between and among units of state and local government, as well as the provider community, is essential.

Currently, 83,000 Rhode Island children receive Medicaid benefits through a variety of delivery systems. Medicaid funding provides a broad range of health care services to children and their families through DCYF, DHS, DOH, MHRH, and the local education authorities. Medicaid funds comprehensive health insurance for many DCYF children, including behavioral health services, through Rite Care as well as fee for service, and a large number of children "touched" by DCYF services are enrolled. Further, it is clear that Medicaid's value to the system can only be realized if, at a minimum, current eligibility standards are maintained – any change in this public policy reduces resources available for this system change.

At the same time, Medicaid is a broad entitlement program with very stringent requirements governing eligibility service definition, and reimbursement. Limits on utilization, provider participation, or consumer choice are not permitted. This set of standards has clear programmatic and budgetary implications, and may mean that Medicaid funding is not universally attractive. However, it is also clear that Medicaid, particularly in light of the mandate of EPSDT (Early Periodic Screening, Diagnosis, and Treatment), needs to be fully leveraged.

This leverage can be accomplished by Comprehensive Care Networks being sufficiently knowledgeable to be able to refer to and otherwise make use of services available to children throughout the rest of the Medicaid system. In this way, Medicaid-financed services can

"wrap" around services provided by and through Comprehensive Care Networks. Comprehensive Care Networks do not need to control these dollars, but do need to be able to access them.

Similarly, development of one or more case rates can be phased in over time, as data becomes available to support and justify this structure. Case rates are simpler to administer than encounter-based claiming, but need to be designed to provide the same level of data feedback to inform ongoing decision-making.

For any financing strategy to be successful, it must be guided by constant review of clear, accurate, actionable data that describes the operation of the system overall. This data, at minimum, must include caseload (the number of active eligibles), expenditure (both on an individual level, as well as projected for the system as a whole, based on current eligibility and patterns), and outcomes (the result realized in consequence of the expenditure, based on an understanding of the need at the onset of the expenditure).

Rate structure is an essential element of any financing strategy. Rates must be established in a rational fashion that blends considerations of cost, capacity, and outcomes, and then maintained in a disciplined fashion. If we value evidence-based services, they should be reimbursed based on performance. The State should pay the same rates for like services across all programs and departments, but should not pay higher rates than other payors unless a sound rationale that supports the outcomes desired for the system can be articulated. Coordination and cooperation among state departments is critical to address these issues.

Development of funding strategies must be concurrent with system of care design and development, focused on maximizing resources that support the needs of the children. Program and fiscal staff, across departments and agencies, must both be intimately involved in planning and development.

The main financing challenges facing the system are:

❑ How to design a system of performance risk offset by financial reward;

❑ How to "transplant" monies invested in the current system to the allocation (sites, practices, and modalities) required by the new system;

❑ How to do so without sacrificing the current system as it is needed until the new system is fully developed; and

❑ How to fund this transition in a reasonably controlled way.

Some type of all-encompassing rate(s) that reflect a fully mature system's operation and contribution may be optimal. The development of such a structure would take significant time and in-depth analysis.

In the interim, these challenges can be addressed with an interlocking strategy of "wrap-around" models and incentive rates. Comprehensive Care Networks would be paid one or more "base rates" for common core services provided to all children with whom they would become involved (embedding the costs necessary to provide general administrative supports to the Regional Offices). For the purpose of DCYF Comprehensive Care Networks, the base rate would cover services not otherwise billable to other payors. Services required to support an individual child would be billed over and above the base rate to whatever payor was most appropriate, based on individual circumstances (including but not limited to Medicaid, health

insurers, school systems, and parents): funding for any child is truly individualized, and all funding sources are involved. This is a demanding role for the Comprehensive Care Network entity, but one that can be rewarded with an accompanying set of payment incentives.

FINANCING THE SYSTEM OF CARE RECOMMENDATIONS

1. **DCYF should assure that they will make every effort to ensure that Comprehensive Care Networks are informed by, and incorporate as appropriate, the CEDARR certification standards for those functions that are embedded in the role of the Comprehensive Care Networks. Attention will also be paid to ensuring that appropriate service providers are enrolled as providers in the networks of the RIte Care health plans. The intent of this recommendation is to assure that existing system resources are effectively utilized and to avoid supplantation and duplication of services.**

2. **$ The Children's Cabinet should establish a permanent financing workgroup that complements and supports the Caseload Estimating Conference by examining trend data and projections for children served by all Children's Cabinet agencies.**

    A. **The permanent financing workgroup of the Children's Cabinet makes recommendations to the Cabinet regarding consistent rates of payment for similar services across programs and populations and will address the following:**

        i.   **adequacy with respect to cost of service,**

        ii.   **incentives to develop needed capacity,**

        iii.   **routine updating of rates over time and evaluation in light of the outcomes achieved by each service and program**

        iv.   **transitioning of contracts and services to performance-based rates.**

        v.   **working with the Department of Human Services, the development of a capacity to routinely assign financial responsibility to private insurance carriers, where they should be the primary payor, including coverage for early intervention services as well as comprehensive mental health and substance abuse treatment for both the covered children and adults.**

        vi.   **identification of common outcomes for services affecting children across all departments and programs**

        vii.   **serve as a forum for the defining of uniform performance standards regarding service definitions to be recommended for use by state agencies for contractual purposes.**

3. **$ DCYF must engage consultants to assist the agency in accurate expenditure and population projections for financial planning purposes.   This must include**

partnering with DHS and other state agencies to proactively estimate caseloads in order to develop realistic budgets and spending plans.

The ability of DCYF to accurately project populations and expenditures is key to the success of DCYF and the system of care to control costs while ensuring access to quality services for target populations. The consultants working with DCYF must be experienced in interpreting historic data and developing utilization and expenditure trends. These consultants study data from both DCYF and from Medicaid and project utilization and expenditures for both sources of funds.

4. $ **DHS must work with other state agencies, managed care vendors and their behavioral health subcontractors to develop a reimbursement system that attracts behavioral health providers and increases the number of such providers available through the Medicaid program and other health care insurers. In addition to adequate rates of reimbursement, this effort must also focus on ensuring the availability of financing to support system/capacity building (i.e., training, loan guarantees, community capitalization).**

Feedback from numerous forums include criticism of the reimbursement rates for behavioral healthcare providers through the Medicaid program and other health insurers. This has led to a sharp decline in the number of behavioral health professionals, particularly child and adolescent psychiatrists and licensed social workers, practicing in Rhode Island. Although this must be addressed on several fronts, including the training programs for these professionals, it is extremely important that the DHS lead state agencies and other key stakeholders in an effort to examine reimbursement rates and develop a reimbursement system that provides adequate reimbursement and can be easily adjusted to meet market demands.

5.   **The Rhode Island General Assembly recognizes the importance of parity in relation to the coverage by health care insurers for treatment of mental illness and substance abuse[17]. This Task Force fully supports this effort and urges the Departments of Health and Business Regulations to move forward with insurers to ensure full implementation as quickly as possible. Specific attention must be given to the issue of the barriers created by the credentialing processes used by insurers.**

The report of the Surgeon General on Mental Health[18] clearly articulates the need for mental health parity coverage by health insurers. Untreated mental illness in children

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[17] RI Public Law 2001-409 An Act Relating To Insurance Coverage For Serious Mental Illness

[18] The foremost finding in the Surgeon General's report is that [nationwide] most children in need of mental health services do not get them (p. 180). The conclusion that a high proportion of young people with a diagnosable mental disorder do not receive any mental health service at all (Burns, et al., 1995; Leaf et al., 1996) reinforces an earlier report by the US Office of Technology Assessment (1986) which indicated that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services. Only one in five children with a serious emotional disturbance used mental health specialty services although twice as many such children received some form of mental health intervention (Burns et al, 1995). Thus, about 75 to 80 percent fail to receive specialty services, and the majority of these fail to receive any services at all, as reported by their families (Surgeon General's Report, 2000, p180)"

and adults is a significant drain on our economy and devastating to individuals and families. Enhancing coverage of mental health and substance abuse in private health insurance programs can only serve to improve the quality of life for our children and families and to support our economy. The State's new mental health parity statute is a first step in this direction. Credentialing issues create barriers in two ways: one, these limit the array of professionals and para-professionals that can practice and get reimbursed; two, the procedures are so arduous and onerous that providers often wait long periods of time to receive approval and bear the burden of the cost of providing services during this waiting period.

6. $ **The DHS must continue its efforts to ensure that all children are covered by health insurance through focusing on further reducing the number of uninsured children in Rhode Island through expanded Medicaid/SCHIP access. To accomplish this, DHS maintains RI Medicaid's current definitions of medically necessary services and assures that all Medicaid primary care providers deliver all EPSDT services. DHS must continue to extend Medicaid benefits to children and adolescents covered by SCHIP. In conjunction with the MHRH, the DHS assures that parents of both Medicaid and SCHIP covered children receive needed mental health and substance abuse treatment.**

The DHS is nationally recognized for expanding access to Medicaid for eligible children. This progressive approach has led to Rhode Island being the top state in regard to the number of children covered by health insurance[19]. Rhode Island's Continuum of Care must continue this effort and support the DHS in expanding access to Medicaid.

7. $ **The DHS, in collaboration with other state agencies, must ensure that Medicaid eligible children receive timely and appropriate assessments throughout their development. The DHS must emphasize that primary care providers use age appropriate screening for child/adolescent mental health and substance abuse problems. The DOH, the DHS, and DCYF must work collaboratively to ensure that children from birth to age three involved with DCYF are referred to Early Intervention programs for screening, assessment, and treatment as needed.**

There is a strong need for timely and quality assessments and evaluations for children and youth at all stages of the developmental continuum. Recent changes in the Early Intervention Program and the development of the CEDARR Family Centers show promise in being able to increase access to these services. State agencies must continue to work together in expanding this access and ensuring that a multi-disciplinary team approach be utilized.

8.   **It is important that the system of care include independent local providers** *(see Appendix J)* **who may be able to intervene with children and families before tragedies happen or the children need to be removed from their homes. The Children's Cabinet, through a designated agency or committee, must work with**

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[19] According to the Annie E. Casey Foundation's National KIDS COUNT data, only seven percent (7%) of Rhode Island children are uninsured compared to a national average of fifteen percent (15%). 200l KIDS COUNT Data Book Online at http://www.aecf.org/cgi-bin/kc2001.cgi?action=profile&area=Rhode+Island

independent behavioral health providers and third party insurers to ensure the prompt and appropriate reimbursement for services and to ensure access to appropriate mental health services. Prompt and adequate payment from insurers and from the state will help to enhance and maintain a core of such providers. It is also important that subscribers receive appropriate treatment to effectively deal with their issues and not be cut short due to insurance limits.

CHAPTER 5: WORKFORCE DEVELOPMENT

Workforce development is a critical component of the system of care. Workforce development includes but is not limited to:

❑ Undergraduate/graduate education

❑ Recruitment

❑ Pre-service education

❑ In-service education

❑ Professional Development

❑ Retention

The children's' services area has historically lagged nationwide in a meaningful investment into this important area of infrastructure development. The system places a high priority on this investment in human capital. DCYF works closely with the Department of Health, the Office of Higher Education, colleges, universities, and public and private providers to address these important issues.

Rhode Island is fortunate to have well-developed higher education institutions at the associate, baccalaureate, and graduate levels. In this system, DCYF, through the Child Welfare Training Institute, works closely with relevant department chairpersons at these institutions to assure that the curriculum reflects up-to-date evidence-based best practices in the child welfare, mental health, juvenile justice, social work, and substance abuse fields. Appropriate undergraduate curricula are developed to prepare students for the varied functions needed in both the public and private sector children's services field including but not limited to:

❑ Family Based Care and Family Centered Practice

❑ Residential services and care

❑ Case management

❑ Clinical practice, especially child and family psychologists and child and adolescent psychiatrists

❑ Supervision

❑ Wraparound services

❑ Management and administration

Mechanisms exist to ensure that there is an appropriate supply of paraprofessional caregivers and licensed professionals at all levels, including family service coordinators, licensed social workers, licensed mental health counselors, licensed marriage and family therapists, licensed chemical dependency counselors, licensed child psychologists, and child and adolescent psychiatrists. The Department of Health and the Office of Higher Education lead the Cabinet's efforts to work with institutions of higher education to train and educate these professionals. State agencies and private providers collaborate to develop and implement

policies and practices which enable the recruitment and retention of highly qualified professionals to work in Rhode Island.

Recruitment of qualified candidates is essential for the work of the system of care. DCYF and the community providers combine recruiting efforts on college campuses, job fairs, community center career fairs, etc. to maximize resources as well as to assist potential candidates to distinguish among career choices. Both DCYF and community providers establish minimum educational criteria required for positions and assure that new recruits meet or exceed these requirements.

While individuals may choose to move across the public and private sectors, it is also essential that, for those who desire a position in either sector, professional development plans are in place that enable them to develop professionally and to pursue upward mobility through advanced level training and expanded educational opportunities in each sector.

WORKFORCE DEVELOPMENT RECOMMENDATIONS

1.   **The Director of the Child Welfare Training Institute must work closely with other DCYF administrators and community providers to ensure that quality training and support is available to biological parents and kin, foster parents, pre-adoptive and adoptive parents, court appointed special advocates, family service coordinators, and staff who provide care or services to children and their families.**

Training and support are also essential for the large number of individuals, who, though not employed by the public or private sector make an essential and enormous contribution to the children's services delivery system. This group includes but is not limited to foster parents, court appointed special advocates, public and private agency staff and volunteers, and pre-adoptive and adoptive parents. The Director of the Child Welfare Training Institute and the Institute's staff are responsible for working with public and private agency staff and representatives of all these groups to design and implement appropriate training curricula and on-going support opportunities for these most important participants in the system of care.

2.   **The Director of the Child Welfare Training Institute must work closely with other DCYF administrators, other state agencies, professional associations, guilds, community providers and other key stakeholders to ensure that quality training and support is available healthcare professionals providing services in the system of care.**

Ongoing training and support is key to the development and maintenance of a strong healthcare workforce. The Director of the Child Welfare Institute and Institute staff must work closely with professional associations and guilds to review and make recommendations regarding how current Continuing Education Unit (CEU) requirements could be enhanced to address education regarding the system of care. Similar discussions should be held with universities and colleges in the State regarding their graduate training programs.

3.   **The Department of Health, the Department of Elementary and Secondary Education and the Office of Higher Education should collaboratively lead the**

Children's Cabinet's efforts in developing strong relationships with RI's academic community to achieve the following goals:

A. **An increase in the quantity and quality of licensed professionals choosing to practice in Rhode Island, especially child and family psychologists, child and adolescent psychiatrists, and licensed social workers, licensed mental health counselors, licensed marriage and family therapists, and licensed chemical dependency counselors;**

B. **An increase in the quality and quantity of learning opportunities (i.e., internships, residencies, clinical practice experiences) for students at all academic levels;**

C. **The development of curricula reflective of current best practices in children's services, including children's behavioral health, juvenile justice (including newly developed best practices in gender and culturally competent practice and programming), and child welfare.**

4. **The Implementation Committee for the System of Care must identify and develop methods to provide ongoing support for pediatric/primary care practitioners, including but not limited to:**

A. **Examining and revising reimbursement structures by which Health Plans/Insurers reimburse for child and adolescent psychiatric services to ensure that rates support actual service costs;**

B. **Developing web-based consultation and support for pediatric/primary care practitioners;**

C. **Considering the creation of a child behavioral health consultation team to provider direct support to pediatric/primary care practitioners in order to increase the capacity of behavioral health care available to children and their families. This team would include child and adolescent psychiatry, nursing and other behavioral health practitioners.**

The Task Force recognizes the vital role that pediatric/primary care practitioners play in the screening, the early intervention and the ongoing care and treatment of children with behavioral health disorders. As such, the are an integral part of the system of community-based care. Partnering with higher education, (Brown University School of Medicine, Rhode Island College School of Social Work, and Salve Regina's and University of Rhode Island's Schools of Nursing), the Task Force seeks to establish and maintain ongoing professional development in the area of children's behavioral health for pediatric/primary care practitioners. Given the acknowledged shortage of behavioral health practitioners, the Task Force recognizes the importance of the intentional provision ongoing support from behavioral health practitioners to pediatric/primary care practitioners via web-based and other forms of ongoing consultation.

5. **$ Community providers, with appropriate assistance as needed from state agencies, must continue to develop compensation and benefits packages designed to retain workers in the community non-profit sector and reverse the trend of the**

non-profit sector serving as the training ground for movement into the public sector.

In order for the system of care to be implemented it is essential to develop and retain a well-trained, well-organized private vendor system that retains workers and develops qualified and experienced supervisors and managers. Effective compensation packages are key to the success of this retention effort. While individuals may choose new positions for growth and increasing or different responsibilities, because of the increasing responsibilities of the private sector in the system of care, it must be an attractive option for both new and experienced workers.

6. $ **The RI Child Welfare Training Institute must work with the academic and provider communities to formalize and expand cross training opportunities between the public and community non-profit sectors at all levels.**

Quality in-service training is essential for quality services to be available to children and families. While there has been in-service cross-training in the past between DCYF and provider agencies these efforts must be formalized and expanded. A core orientation curriculum should be jointly developed so that beginning case managers in the community non-profit sector have the same foundation knowledge, values, and skills as case managers in the public sector. By training staff together, all workers will better understand and appreciate the nuances of each system, the complementing of roles and responsibilities, and the need for teamwork throughout the system. Following the development of a foundation curriculum, advanced level cross-training topics are developed that further solidify the partnership model. Because in many private agencies, training budgets tend to be limited, a pooling of resources and dollars allow for maximizing resources. Multiple training methods must be utilized, including but not limited to computer assisted education and distance learning techniques.

7. $ **DCYF must work with the Department of Administration and labor unions to build in a requirement that all supervisors within DCYF must hold a minimum of a masters' degree in social work or a related field. The number of scholarships available to DCYF staff must be increased to support this requirement.**

High quality supervision is valued in the system of care, thus supervisors are given reasonable worker caseloads; time is budgeted for weekly worker supervision; a system is in place to address worker problems early on; and clear personnel policies identify the supervision, worker evaluation, and progressive discipline plans. Supervision is an important element of each staff person's personal growth and development. It is extremely important that supervisors have the knowledge, skills, and experience needed to provide effective mentoring and supervision to other staff. Individuals with masters' level training have the minimum knowledge necessary to be successful as a supervisor. In implementing this recommendation, attention must be given to providing courses in the community and at times which allow for access by a diverse group of individuals. As well, it is critical that DCYF increase the availability of scholarships to qualified staff for the purposes of pursuing graduate level training. Similarly, supervisors in DCYF provider agencies should be required to have a masters' degree.

8. **DCYF must continue to embrace cultural diversity and cultural competence by**

expanding its efforts to build a culturally diverse and culturally competent workforce internally and within vendor agencies.

Cultural diversity and cultural competency *(See Appendix C)* are essential for the System of Care at all levels. DCYF developed a plan to become an affective multi-cultural organization in response to Recommendation 14 of the Governor's Commission to Study the Placement of Children in Foster and Adoptive Care[20] DCYF will address issues of cultural and ethnic competency and diversity through training to staff and all participants in the children's services delivery system. The Department will consult with the National Technical Assistance Center for Cultural Competence and other national resources to assure that the system provides services and supports that are sensitive to the importance of these issues.

9.   **DCYF must continue to embrace gender-specific programming and practice by expanding its efforts to build a workforce, internally and with vendor agencies, that is educated about gender issues.**

Gender-specific programming *(see Appendix N)* is essential for the system of care at all levels.   This requires that administrators and staff internally and within vendor agencies are aware of the unique developmental pathways of males and females, and how their development and unique risk factors affect their responses to certain interventions. As previously mentioned, juvenile corrections programming has been developed to meet the needs of a predominantly male population.   As females' involvement in the system increases, there is a critical need to orient programming and practice to their unique, gender-specific needs to maximize program effectiveness and reduce recidivism.   In response to the Juvenile Justice and Delinquency Prevention Act's directive to improve programming and practices for females in the juvenile justice system, the Department has begun to educate staff at the Training School and will be providing staff training to a sample of contracted program vendors. It will be essential to expand this effort by accessing trainers and technical assistance providers and by consulting with the Office of Juvenile Justice and Delinquency Prevention Training and Technical Assistance Center.

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[20] *Strengthening Partnerships for the Safety and Success of Rhode Island's Children: The Report of the Governor's Commission to Study the Placement of Children in Foster and Adoptive Care, (July 1999).* Providence, Rhode Island: Department of Children, Youth and Families. See Recommendation 14, p. 20.

CHAPTER 6: PERFORMANCE MEASURES AND OUTCOMES

Key to the success of the system is the ability to effectively measure and evaluate system performance and client outcomes for children, youth and families and to use these evaluations to modify and further develop best practices. The system highly values the importance of effective performance and outcome measurement at all levels.

The system of care's culture supports evaluation and employs a comprehensive evaluation strategy including the three components of **context evaluation, implementation evaluation and outcome evaluation** *(see Appendix K).* This provides a sophisticated analysis of how and why programs and services work, for whom they work, and under what circumstances they work. The system of care evaluation component:

❑ Examines how the system functions within the economic, social, and political environment of its community and setting (context evaluation);

❑ Supports the planning, set up, and implementation of the system as well as documents the evolution of the system (implementation evaluation); and,

❑ Assesses the short and long-term results of the system (outcome evaluation).

These three measurements serve as the foundation and guide for the development of performance and outcome recommendations for the system of care. The recommendations themselves are tiered to focus on the need for a higher level system reform that must be maintained within the authority of the Children's Cabinet and to recognize the work necessary at the level of state departments - individually and collectively.

On a direct agency level, there is a recognition that DCYF is accomplishing two distinct goals. One is building system capacity. The second is developing a regionally based network system of care which is specifically designed to address increasing demands and changes in service needs for children and families at varying levels of intensity in a community context.

Moreover, the Children's Cabinet continues its work with RI KIDS Count to develop child indicators to assist the state in achieving the four outcomes adopted by the Cabinet and state agencies. Toward this end, DCYF and other state agencies continue their work in building performance measures and outcomes into service delivery both internally and with providers.

PERFORMANCE MEASURES AND OUTCOMES RECOMMENDATIONS

1. $ **The Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of this plan must include families (parents, kin, foster and adoptive families).**

     It must be recognized that there is a significant cost associated with developing the appropriate infrastructure to accommodate these information requirements, and the State must establish this as a priority investment. Each Department must identify its own financing needs for enhancing the data collection and analysis capability for its own services and population, and the provider community must to do the same. This

data collection and analysis capability must be incorporated into state budget appropriations for the Departments within the Children's Cabinet. An overview of the five year phase-in plan and implementation process lays out the expectations for the critical work that will be necessary to achieve this first recommendation over the five year project period. *(See Appendix K)*

2. $ **DCYF must develop and implement a work plan that is geared to measure:**

❑ **progress in system of care development and**

❑ **the effectiveness of the interventions ascribed to the system.**

The information gathered must also be distributed to identify problems, make adjustments to improve system design and to ensure public accountability.

The Department of Children, Youth and Families has established five goals to guide its system of care capacity development. These broad goals reflect the Department's emphasis on community-based, family-centered services to ensure greater capacity for necessary placements close to the child's home/community. An overview of the workplan for DCYF System of Care Capacity Development and Performance Measures provides a five year approach identifying the key objectives necessary to achieve the goals. *(See Appendix K)*

The priority reform performance measures in the system reform are:

❑ Eliminate night-to-night placements

❑ Eliminate medically unnecessary days in psychiatric hospitals

❑ Reduce out-of-state placements

All of the performance measures, however, identify key data elements being tracked for the Department's operations in promoting continuous quality improvement in Child Welfare, Children's Behavioral Health, Juvenile Corrections, and Independent Living program functions.

3. $ **Rhode Island KIDS COUNT should continue to track child abuse and neglect, out-of-home placement, children's mental health, education, and juvenile justice indicators to measure results such as trends in numbers of out-of-state placements and foster care.**

The foremost public policy principle for the State is that, unless there is reason for a child to be removed from the home due to abuse or neglect, significant mental or behavioral health needs requiring out-of home care, or juvenile delinquency, **the needs of a child or youth are best met by maintaining them in their home with their family and providing the necessary support services to make this work**. However, when it is necessary to remove a child and place them in out-of- home care, it is the desire of the state that this substitute care be in the setting that is least restrictive and most effectively meets that individual child's needs. In this regard, the data collected by RI KIDS Count will assist the state in measuring what proportion of children and youth are in foster care vs. therapeutic foster care vs. congregate and institutional care. The expectation is for this data to show that a greater proportion of children and youth

are being served in less restrictive settings as opposed to more restrictive settings, especially younger children.

4. $ **DCYF must lead the development of performance measures and outcomes for Comprehensive Care Networks. This will be aimed at measuring both the lead agency itself as well as the performance of subcontracted entities in meeting the needs of children and families served. DCYF will develop utilization management and quality assurance mechanisms which will include family input/participation. These mechanisms will assess the implementation of a consistent standard of practice within the Networks that embodies the principles of the system of care.**

DCYF will use performance measures previously established in partnership with Yale University for outreach and tracking, foster care, shelter care, and residential programs. These and other standards, such as the CEDARR Family Center Standards, will be used to inform and guide the development and implementation of the development of a Comprehensive Care Network systems' evaluation component to include performance and outcome measures.

CHAPTER 7: IMPLEMENTATION

No plan of action is successful without clear articulation of roles, responsibilities, benchmarks, and time frames. The reorganization of Rhode Island's system of care for children, youth, and their families is no different. Numerous state, community, public, and private stakeholders are involved in each of the recommendations presented. The stakes are high for providers, state agencies, the Judicial Branch, and the Legislature and especially for the children and families served. It is imperative that there is clear designation of who, what, when, where, and how each of these recommendations will be implemented.

IMPLEMENTATION RECOMMENDATIONS

1. **The Task Force recommends the creation of a System of Care Implementation Committee which will temporarily oversee the implementation of the recommendations contained in this report. In carrying out this charge, the Implementation Committee must ensure that they consider how to blend the recommendations of the Task Force's Foster Care and Current Reality Committees (*See Appendices L and M)* into the new System of Care.**

    The Task Force recognizes the role the Children's Cabinet is intended to and has played in strategic planning for policies and services affecting children, youth and families. However, the Task Force realistically understands that in this election year it is unclear as to the future direction of the Cabinet. In order to ensure that a vacuum doesn't occur which tables moving forward on these recommendations, the Task Force believes that the creation of an Implementation Committee is a prudent interim step. This committee should be modeled after the successful Welfare Reform and Starting RIght Implementation committees and contain a broad representation of legislators, executive branch leadership, judicial leadership, families, providers and other key stakeholders.

2. **The Governor must ensure that the Children's Cabinet is provided with the leadership and support necessary for the Cabinet to succeed with its mission of interagency collaboration and planning and oversee the implementation of this plan.**

    A. **In order for the Cabinet to be able to effectively meet this and its other responsibilities, the Cabinet must be restructured in a manner which provides a greater depth of staff level involvement and commitment and a greater ability to provide forums for state agencies to work collaboratively on issues that does not interfere with the public's access to the Cabinet.**

    B.   **The Governor and the Cabinet should review the Cabinet's enabling legislation (RIGL 42-72.5) and recommend to the General Assembly changes to which will provide the Cabinet with the direction and flexibility needed to accomplish this restructuring.**

The systemic changes called for in this report require strong collaboration between and among state agencies as well as between and among the Executive, Legislative, and Judicial branches of government. The Children's Cabinet provides an existing structure within the Executive Branch to oversee and implement this plan. However, in order to accomplish this responsibility, it is clear that the Cabinet must restructure itself in a manner that provides for greater interagency collaboration as well as greater involvement from the Legislative and Judicial branches of state government. In this restructuring, the Cabinet must identify mechanisms which provide for the creation of interagency staff level work teams for prevention, financing and system management planning, development and implementation. In developing these teams, the Cabinet must consider how to most effectively involve the Legislative and Judicial branches of government, the Offices of the Attorney General and Public Defender, and non-governmental organizations and individuals.

3. $ **DCYF must designate a key staff person who will be responsible for the oversight of the implementation of these recommendations. This individual must have the ability to work with all of the stakeholders involved, be willing and able to keep agencies and individuals within DCYF and from other agencies and stakeholder groups on task.**

Most of the recommendations contained in this report fall on the shoulders of DCYF to implement or to collaborate with other stakeholders to implement. It follows that DCYF be held responsible for overseeing the implementation process. However, it is imperative that the staff person designated be relieved of other duties in order to pay full attention to the goal of changing Rhode Island's System of Care. This is obviously no easy task and will require tremendous time, energy and skills from the Project Manager. This person must be at least temporarily added to the Senior Team for DCYF. This individual reports directly to the Director of DCYF.

4.   **The Task Force recognizes the need for a clear implementation timeline but also understands that many details still need to be delineated. The five-year timeline below is intended to serve as a preliminary workplan to be used by the Children's Cabinet and the Implementation Committee. Those groups will need to develop a more concrete timeline as one of their initial actions.**

YEAR ONE

A.   **Appoint System of Care Implementation Committee members, provide committee with mission and direction.**

B.   **Restructure the Children's Cabinet, including the introduction of any legislation necessary to accomplish this restructuring.**

C.   **Appoint a DCYF Project Manager.**

D.   **Clarify, measure, and affirm DCYF priority populations.**

E.   **Engage and mobilize key stakeholders (legislature, judiciary, community leaders, advocates, families, DCYF staff, providers etc) through mechanisms included but not limited to:**

      i.   **Legislative briefings;**

      ii.   **Meetings with the Judiciary and their staff;**

      iii.   **Public Hearings;**

      iv.   **Meetings with state agency administrators and their staff (DHS, DOH, MHRH, RIDE, etc.);**

      v.   **Meetings with LEA administrators (superintendents, special education administrators, etc.);**

      vi.   **Memoranda of understandings between and among all involved parties.**

F. **Establish DCYF Planning, Analysis and Evaluation capacity by identifying DCYF staffing capacity and, as necessary, subcontracting for specific expertise to:**

      i.   **Determine historical costs;**

      ii.   **Analyze DCYF and Medicaid expenditures;**

      iii.   **Conduct provider profiling, needs assessment;**

      iv.   **Determine which, if any, services will be procured statewide (ex. Juvenile sex offender treatment);**

      v.   **Establish quality indicators, performance measures, and benchmarks;**

      vi.   **Facilitate program development;**

      vii.   **Analyze the feasibility of using a case rate payment mechanism for Comprehensive Care Networks;**

      viii.   **Begin development of RFP's for Comprehensive Care Networks;**

      ix.   **Begin to produce reports to be used as a baseline for the evaluation process.**

G. **Establish Children's Cabinet functions and performance measures:**

      i.   **Review and revise RI statutes and agency regulations as necessary;**

      ii.   **Begin development of Information and referral system;**

      iii.   **Establish Community Prevention Partnerships;**

      iv.   **Develop five year projected Child and Family budget (including federal, state and local funds) to support the implementation of the system of care;**

      v.   **Develop performance measures for Children's Cabinet functions.**

H. **Implement Coordinated Children's Services System Regulations:**

i. **Operationalize pilot project;**

ii. **Evaluate project, with ongoing feedback from family members, and use information to inform Lead Agency procurement process and guide the CMT process.**

I. **DCYF to establish and implement agreements with the Family Court, RIDE, DHS, DOH and MHRH**

J. **Redesign DCYF Organizational Structure:**

i. **Restructure DCYF Central Office to support new regional structure;**

ii. **Establish DCYF Regional structure, staffing patterns, and regional budgets;**

iii. **Establish DCYF Regional Directors with regional budget authority, reporting requirements.**

K. **Establish Workforce Development focus:**

i. **Develop curricula for pre-service and in-service training . Such curricula must include training on family centered practice, cultural competency and gender specific programming;**

ii. **Support training for public and private provider staff with emphasis on best case management and clinical practices, family centered practice, cultural competency and gender specific programming;**

L. **DCYF to review substance abuse system with MHRH and determine how to move collaboratively forward;**

M. **Issue first annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.**

YEAR 2

A. **Implement changes to DCYF Regional Structure.**

B. **Expand DCYF Planning, Analysis and Evaluation capacity:**

i. **Review and utilization of reports used for baseline;**

ii. **Enhance and integrate DCYF and provider MIS systems as necessary.**

C. **Expand DCYF Workforce Development responsibilities:**

i. **Charge Child Welfare Training Institute to develop provider fiscal, management, and clinical skills;**

ii. **Establish on-going required and recommended pre-service and in-service training. This must include training in regard to family centered practice, cultural competency and gender specific**

programming.

D. Develop DCYF/Medicaid Provider Capacity:

    i.   Address provider reimbursement issues;

    ii.   Develop/expand key services in treatment continuum in partnership with family members.

E. Phase in the transition of youth placed out-of-state to newly developed in-state capacity on fee-for service basis as possible.

F. Develop behavioral health requirements for private insurers:

    i.   Examine current state statutes (i.e., parity) and regulations;

    ii.   Amend statutes and/or regulations as needed to assure behavioral health screening, assessment and treatment coverage.

G. Establish DCYF Lead Agency procurement policies through the development of the Care Network RFP   Identify vision, mission, roles and responsibilities:

    i.   Establish appropriate payment mechanism;

    ii.   Develop fiscal accountability structure for providers;

    iii.   Establish Lead Agency performance indicators;

    iv.   Identify incentives/penalties for lead agencies;

    v.   Bring Regional Lead Agencies on-line.

H. Establish Comprehensive Care Networks:

    i.   Determine sub-contract requirements and financing arrangements;

    ii.   Establish sub-contractor quality indicators and performance measures;

    iii.   Procure lead agency subcontractors.

I. Transition youth in traditionally contracted and POS out-of-home care from current system to comprehensive care network system.

J. Issue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 3

A. Adjust payment rate structure (and risk arrangements) as necessary.

B. Continue emphasis on DCYF workforce development, DCYF/Medicaid program development and pre-service and in-service training with a focus on family centered practice, cultural competency and gender specific programming.

C. Continue the transition of youth in traditionally contracted and POS contracted out-of-home care to comprehensive care networks.

D. Continue the design and implement evaluation of Comprehensive Care Networks for out-of-home care.

E. Design and implement evaluation of Comprehensive Care Networks for home and community-based services.

F. Begin longitudinal study of children and youth involved in Comprehensive Care Networks.

G. Issue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 4

A. Refine fiscal and management reporting.

B. Continue evaluation of Comprehensive Care Networks for out-of-home services.

C. Transition children and families receiving home and community-based services at point of entry to Comprehensive Care Networks.

D. Continue evaluation of Comprehensive Care Networks for home and community-based services.

E. ssue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 5

A. Produce comprehensive system of care evaluation report including but not limited to analyses of access, services utilization, quality and performance measures, and cost-effectiveness.

B. Revise system of care design/implementation based on evaluation findings and recommendations.

C. Issue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

APPENDICES

APPENDIX A: RHODE ISLAND SYSTEM OF CARE TASK FORCE MEMBERS AND COMMITTEE PARTICIPANTS

TASK FORCE MEMBERS

Participant		*Agency*
Hon. Thomas J.	Izzo	Co-Chairman; RI Senate
Hon. Steven M.	Costantino	Co-Chairman; RI House of Representatives
Dr. Robert	Carl	Co-Chairman; Department of Administration
Cathy	Ciano	Parent Support Network
Margaret	Alves	RI Foster Parent Association
Mary	Brinson	Butler Hospital
Elizabeth Burke	Bryant	RI KIDS Count
Laureen	D'Ambra, Esq.	Chairwoman, Current Reality Committee; Office of the Child Advocate
Thomas	DiPaola, Ph.D.	Department of Elementary and Secondary Education
Elizabeth V.	Earls	RI Council of Community Mental Health Organizations
Hon. Gordon D.	Fox	RI House of Representatives
Hon. Aram G.	Garabedian	RI Senate
Clark	Greene	Office of the Governor
William	Guglietta, Esq.	Department of the Attorney General
James	Harris	RI Council of Residential Programs for Children and Youth, Inc.
Calittia	Hartley	Department of Human Services
Jane	Hayward	Department of Human Services
Hon. Jeremiah S.	Jeremiah, Jr.	Chief Judge, RI Family Court
Dennis	Langley	Urban League of Rhode Island
David	Lauterbach	Kent County Mental Health Center
Paul	Lemont	RI League of Cities and Towns
Jay G.	Lindgren, Jr.	Department of Children, Youth and Families
Luisa	Murillo	Chairwoman, Foster Care Committee; Center for Hispanic Policy and Advocacy, Inc.

TASK FORCE MEMBERS (CONTINUED)

Participant		*Agency*
Dennis	Murphy	United Way of Rhode Island
George	Nee	Rhode Island AFL-CIO
A. Kathryn	Power	Chairwoman, Ideal System Committee; Department of Mental Health, Retardation and Hospitals
Br. Michael	Reis	Tides Family Services
Kim	Rose	Office of the Governor
Chief Anthony	Silva	RI Police Chiefs' Association
Dr. Elizabeth	Wheeler	Bradley Hospital

CURRENT REALITY COMMITTEE PARTICIPANTS

Participant		*Agency*
Laureen	D'Ambra, Esq	Chairwoman, Current Reality Committee; Office of the Child Advocate
Br. Michael	Reis	Tides Family Services, Inc.
Lee	Baker	Department of Children, Youth and Families
Raymond	Bandusky	RI Disability Law Center
Thomas	Bohan	Department of Children, Youth and Families
Jennifer	Bowdoin	RI KIDS Count
Mary	Brinson	Butler Hospital
Murray	Brown	Department of Human Services
Hon. Angela	Bucci	Magistrate, Rhode Island Family Court
Mike	Burk	Department of Children, Youth and Families
Michael	Cerullo	Children's Policy Coalition
Erin	Crossman	Rhode Island Family Court
Virginia	da Mota	RI Department of Elementary and Secondary Education
Gail	Dalquist	Placement Solutions
Thomas	DiPaola, Ph.D.	Department of Elementary and Secondary Education
Gail	Dyer	Office of the Child Advocate
Elizabeth	Earls	RI Council of Community Mental Health Organizations
John	Farley	Department of Children, Youth and Families
Deborah	Florio	Department of Human Services
Gregory	Fritz, M.D.	Bradley Hospital
James	Harris	RI Council of Residential Programs for Children and Youth
Calittia	Hartley	Parent
David R.	Heden	Rhode Island Family Court
Berit	Huseby	Office of the Child Advocate
Betsy	Ison	Placement Solutions/Communities for People
Rick	Jacobsen	Department of Human Services

CURRENT REALITY COMMITTEE PARTICIPANTS (CONTINUED)

Participant		*Agency*
David	Lauterbach	Kent Co. Community Mental Health Center
Tricia	Leddy	Department of Human Services
Margaret Holland	McDuff	Family Service, Inc.
Rae	Merliard	Children's Policy Coalition
Sharon	O'Keefe	Office of the Child Advocate
Joan	Obara	Department of Human Services
Mary Anne	Peotrowski	East Bay CASSP
Kim	Rose	Office of the Governor
Carol Spizzirri	Spizzirri	Department of Children, Youth and Families
Charles	Staunton, M.D.	Butler Hospital
John	Young	Department of Human Services

FOSTER CARE COMMITTEE PARTICIPANTS

Participant		*Agency*
Luisa	Murillo	Chairwoman, Foster Care Committee; Center for Hispanic Policy and Advocacy
David	Allenson	Department of Children, Youth and Families
Margaret	Alves	Rhode Island Foster Parent Association
Michelle	Catarino DeJesus	Department of Children, Youth and Families
Paula	Fontaine	Department of Children, Youth and Families
Joel	Gluck	Adoptive Parent
Marie	Masterson	Rhode Island Foster Parent Association
Tom	Ottaviano	Department of Children, Youth and Families
Robin	Perez	Department of Children, Youth and Families
Maureen	Robbins	Department of Children, Youth and Families
Mimi	Romero	Rhode Island Foster Parent Association
David	Small	Family Services, Inc.
Leeann	Sperduti	Department of Children, Youth and Families
Honorable Paul A.	Suttell	Associate Justice, Rhode Island Family Court
Charlene	Zeinowicz	Urban League of Rhode Island

IDEAL SYSTEM OF CARE DESIGN COMMITTEE PARTICIPANTS

Participant		*Agency*
A. Kathryn	Power	Department of Mental Health, Retardation and Hospitals
Margaret	Alves	RI Foster Parent Association
Janet	Anderson, Ed.D.	Department of Children, Youth and Families
C. Lee	Baker	Department of Children, Youth and Families
Jennifer	Bowdoin	RI KIDS COUNT
Mary	Brinson	Butler Hospital
Michael	Burk	Department of Children, Youth and Families
Elizabeth	Burke Bryant	RI KIDS Count
Linda	Carlisle	Consultant
Doreen	Cavanaugh	Heller School, Brandeis University, Consultant
Michael	Cerullo	Private Therapist
Cathy	Ciano	Parent Support Network
Thomas	DiPaola, Ph.D.	Department of Education
Elizabeth	Earls	RI Council of Community Mental Health Organizations
John	Farley	Department of Children, Youth and Families
Hon. Michael B.	Forte	Associate Justice, RI Family Court
Marie	Ganim	RI State Senate, Office of the Majority Leader
William	Guglietta	Department of the Attorney General
Jim	Harris	RI Council of Residential Programs
Calittia	Hartley	Department of Human Services
Jane	Hayward	Department of Human Services
Mitzie	Johnson	Parent Support Network
David	Lauterbach	Kent County Community Mental Health Center
Jay G.	Lindgren, Jr.	Department of Children, Youth and Families
Dennis	Murphy	United Way for Southeastern New England
Michael	Reeves	Harmony Hill School
Kimberly	Rodrigues	RI Council of Residential Programs

IDEAL SYSTEM OF CARE COMMITTEE PARTICIPANTS (CONTINUED)

Participant		*Agency*
Kathleen	Spangler	Department of Mental Health, Retardation and Hospitals
Susan	Stevenson	Children's Mental Health Advisory Council; Providence Center
Elizabeth	Wheeler, M.D.	Bradley Hospital; Children's Policy Coalition

APPENDIX B: PRINCIPLES OF FAMILY CENTERED PRACTICE AS ADOPTED BY THE RI DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

The principles of family centered practice embraced below reflect the Department of Children, Youth and Families investment in developing and maintaining a family centered system of care[21]

- Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate. (This recognizes that "family" may have many interpretations, but maintaining a child(ren)'s connection to his/her family holds significant meaning in their lives).

  - "Family includes biological families, foster families, concurrent planning families, adoptive families, extended family relationships, kinship, etc.

  - Adolescents involved in the Independent Living Program still have need of a family experience and Family-Centered Principles work at assisting maturing youth to identify valuable connective relationships in their life and to build the inner capacity for developing healthy relationships as they reach adulthood.

- Facilitating family/professional collaboration at all levels of well-being

- Recognizing and respecting the racial, ethnic, cultural, sexual orientation, special needs and socioeconomic diversity

- Recognizing family strengths and individuality and respecting different coping methods

- Sharing information between DCYF staff and parents on a continuing basis and in a supportive manner

- Facilitating Family-to-family support and networking. (This includes parent support organizations, interactions between concurrent planning families, foster families, adoptive families, biological families and extended family relationships.)

- Understanding and incorporating the developmental needs of infants, children and adolescents and their families into service delivery systems

- Designing accessible service delivery systems that are flexible, culturally competent and responsive to family needs

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[21] Adapted from Family-Centered Principles found in <u>What</u> <u>is</u> <u>family-centered</u> <u>care?</u> (1990) [brochure] Washington, DC: National Center for Family-Centered Care.

APPENDIX C: DEFINITIONS, CORE VALUES AND STANDARDS OF CULTURAL COMPETENCE FOR RHODE ISLAND'S SYSTEM OF CARE FOR CHILDREN, YOUTH AND THEIR FAMILIES

DEFINITIONS[22]

CULTURE

The thoughts, ideas, behavior patterns, customs, beliefs, values, skills, arts, religions and prejudices of a particular people at a given point in time.

CULTURAL DIVERSITY

The rich mixture of ethnic, racial, religious, national and individual characteristics that colors the landscape of the world in which we live.

CULTURAL COMPETENCE

The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

CULTURAL COMPETENCE CORE VALUES[23]

CULTURAL COMPETENCE IS FOR EVERYONE

Cultural competence is a personal and organizational commitment to learn about one another and how individual culture affects how we act, feel and present ourselves in the work place. The purpose of cultural competence is the sharing of knowledge about all aspects of culture [gender, religion, age, sexuality, education, etc.], not just the racial/ethnic culture of people of color. Cultural competence is an enrichment process, which allows everyone to share and learn. We have to be as willing to share our culture as to learn about another person's.

The vision, mission and goals are the tools the organization can use to create an organizational culture where employees feel comfortable discussing cultural difference and learning about the cultures of other employees and the population served. The organization can also further discussion of diversity by holding events or meetings which encourage people to explore different cultures and have open and honest discussions about difference. Organizations should be willing to allocate resources - money, time , people - to ensure that cultural competence is a priority in the organization.

Each organization has a culture. The communication of the organizational culture should start at the initial interview and continue throughout an employee's time with the organization. While the organization should value difference and be willing to mediate between individual and professional needs of employees, employees should be equally committed to the organizational

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[22] Adapted from *Advancing Cultural Competence in Child Welfare Initiative,* Child Welfare League of America, September 1997.

[23] Adapted from *Advancing Cultural Competence in Child Welfare Initiative,* Child Welfare League of America, September 1997.

culture and be willing to make any necessary compromises in order to be successful in the workplace.

CULTURAL COMPETENCE IS INTEGRAL TO BEST PRACTICE

In order to efficiently and effectively carry out all the processes that are encompassed by best practice, i.e., the planning, organization and administration of social work services; establishment of state and local regulations; content training and teaching in schools of social work; inservice training and staff development; board orientation and development; fiscal planning; and community relations; cultural implications should be identified and integrated into all agency operations. The integration of cultural competence in an organization leads to the development of programs, policies and procedures which value and respect employees, the population served, visitors and others who come in contact with the organization.

CULTURAL COMPETENCE IS AN ONGOING PROCESS

Cultural competence is a journey not a destination. As the challenges facing agencies change, organizations will continuously have to evaluate their ability to meet the needs of their external and internal customers [employees and children, youth and families] in a way that is responsive, effective and culturally competent. When agencies face a new challenge, the cultural competence implications should be identified and addressed. The planning process should include discussion of the cultural implications involved in making any changes.

CULTURAL COMPETENCE IS PART OF THE OVERALL ORGANIZATION GOAL OF EXCELLENCE

In today's arena, program structure, policies and procedures can be duplicated, however, the quality with which they are administered will determine how well the customer is served and how satisfied they are with the service provided. The competition for scarce resources will determine which child welfare agencies emerge on top. Excellence will be defined by the way organizations are run internally, how well programs are administered to the population served, the quality of their staff and image of the organization in the community. The "human factor", i.e. how well employees perform their duties, will be the key to achieving and maintaining excellence. Organizations will be able to distinguish themselves in the marketplace based on how adept their staff is at delivering quality products/services to the customer. The quality of the staff will have more influence on the ability of the agency to compete in the marketplace than the services that are provided. Organizations will need to hire /promote employees who are culturally diverse and dedicated to the mission, core values and goals of the organization. Additionally, they should be willing to continuously cultivate their skill set to learn more about their jobs, the population they serve and their fellow employees.

Cultural issues arise in everyday decision-making. Organizational and/or departmental values are the guidelines which should be used when evaluating options and making decisions. By establishing values that emphasize cultural competence, organizations can ensure that employees have the necessary tools to integrate cultural competence into their daily work routine.

CULTURALLY COMPETENT ORGANIZATIONS ARE CUSTOMER DRIVEN

To be successful in today's environment, agencies will need to be customer-driven. What the population served by the agency expects, needs, wants and is willing to tolerate are considerations which have to be entertained by the agency when designing programs, policies and procedures involved in delivering services. It is important for child welfare organizations to encourage feedback from the population served and to actively solicit their feedback and input for modification.

Agencies also have to understand and value both their internal and external customers. How employees are recruited and retained and how well they service and support one another is as

critical to the efficiency of the agency as how well products/services are delivered to children and families. Therefore, organizations have to encourage feedback from within the organization regarding internal policies, procedures and processes as well as those which affect the population served. Staff members should be as concerned about giving assistance to one another as an external customer. Good internal customer service increases efficiency via the timely transmission of information which is ultimately used to service external customers.

CULTURALLY COMPETENT ORGANIZATIONS FOSTER LEADERSHIP THROUGHOUT THE ORGANIZATION

The environment agencies are exposed to today is in constant flux. The formal leaders of the organization face a new set of challenges which require their attention to keep the organization competitive. By sharing the responsibility of running the organization with the staff of the organization, the formal leaders can create more time for long-range planning themselves. By creating opportunities for leadership throughout the organization, among those who do the work, formal leaders are able to get better information about how the organization is running and what modifications are necessary. Effective team building allows the entire staff to have an impact not only on their own work, but on the overall success of the organization. This instills a sense of pride and ownership which result in commitments the organizational goals of excellence, customer service and quality delivery of a quality service.

Fostering leadership on every level of the organization gives all employees the opportunity to take on responsibility and allows them to hone the skills which will allow them to move up within the organization. The organization benefits because employees are being cultivated to be leaders, which gives the organization a pool of qualified candidates when managerial positions are available. Because there is a lower percentage of people of color when looking for higher level positions, this is another way to increase staff diversity while ensuring quality.

STANDARDS FOR CULTURAL COMPETENCE IN PRACTICE[24]

1. ***Ethics and Values:*** Individuals working within all levels of the System of Care function in accordance with the values, ethics and standards of their respective fields, recognizing how personal and professional values may conflict with or accommodate the needs of diverse children, youth and families.

2. ***Self-Awareness:*** Individuals working within all levels of the System of Care seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.

3. ***Cross-Cultural Knowledge:*** Individuals working within all levels of the System of Care have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems and artistic expressions of major client groups they serve.

4. ***Cross-Cultural Skills:*** Individuals working within all levels of the System of Care use appropriate methodological approaches, skills and techniques that reflect their understanding of the role of culture in the helping process.

5. ***Service Delivery:*** Individuals working within all levels of the System of Care are knowledgeable about and skillful in the use of services available in the community and broader society and are able to make appropriate referrals for their diverse children, youth and families.

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[24] Adapted from *Standards for Cultural Competence in Social Work Practice*, National Association of Social Workers. Online. Available at http://www.socialworkers.org/pubs/standards/cultural.htm 23 June 2001.

6. *Empowerment and Advocacy:* Individuals working within all levels of the System of Care are aware of the effect of policies and programs on diverse client populations, advocating for and with children, youth and families when appropriate.

7. *Diverse Workforce:* Individuals working within all levels of the System of Care support and advocate for recruitment, admissions, hiring and retention efforts in programs and agencies that ensure diversity within the system.

8. *Professional Education:* Individuals working within all levels of the System of Care advocate for and participate in educational and training programs that help advance cultural competence within the system.

9. *Language Diversity:* Individuals working within all levels of the System of Care seek to provide or advocate for the provision of information, referrals and services in the language appropriate to the client, which may include the use of interpreters.

10. *Cross-Cultural Leadership:* Individuals working within all levels of the System of Care are able to communicate information about diverse client groups to other professionals.

APPENDIX D: VALUES AND PRINCIPLES FOR THE FAMILY-CENTERED, COMMUNITY-DRIVEN SYSTEM OF CARE FOR RHODE ISLAND[25]

VALUES AND PRINCIPLES FOR THE FAMILY-CENTERED, COMMUNITY-DRIVEN SYSTEM OF CARE FOR RHODE ISLAND

CORE VALUES

1. The system of care is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care is community based, with the locus of services as well as management and decision making responsibility resting at the community level.

3. The system of care is culturally competent, with agencies, programs and services responsive to the cultural, racial and ethnic differences of the populations you serve.

GUIDING PRINCIPLES

1. Children, youth and their families have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Children, youth and their families receive individualized services in accordance with the unique needs and potentials of each child and family and guided by an individualized service plan.

3. Children, youth and their families receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and/or surrogate families of children and youth are full participants in all aspects of the planning and delivery of services unless such involvement is clearly detrimental to the safety of the child.

5. Children, youth and their families receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.

6. Children, youth and their families are provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

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[25] Stroul, B.A. & Friedman, R.M. (1986). A system of care for children and youth with severe emotional disturbances. (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, p. 18.

7. Early identification and intervention for children, youth and families in need of support and intervention is promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Children, youth and their families are ensured smooth transitions to programs and services in the adult service system as necessary as the youth reaches maturity.

9. The rights of children, youth and their families are protected and effective advocacy efforts for children, youth and their families are promoted.

10. Children, youth and their families receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services are sensitive and responsive to cultural differences and special needs.

APPENDIX E: SERVICE AND PROGRAM COMPONENTS WITHIN RHODE ISLAND'S SYSTEM OF CARE FOR CHILDREN, YOUTH AND FAMILIES

THE PROGRAM AND SERVICE COMPONENTS OF THE SYSTEM OF CARE INCLUDE:

- ❑ General and specialized targeted prevention
- ❑ Early Intervention
- ❑ Quality child care and youth care services
- ❑ Educational Services
- ❑ Medical and dental services
- ❑ Social Skills development
- ❑ School-based mental health services
- ❑ Comprehensive assessments and evaluation
- ❑ Mobile crisis intervention services
- ❑ Case Management
- ❑ Short-term in-home acute care services (i.e., CIS, CES)
- ❑ Outpatient therapy (family, group, and individual)
- ❑ Outpatient Substance Abuse services for children, youth and their families
- ❑ Child abuse and neglect prevention and investigation
- ❑ Therapeutic Recreation
- ❑ Therapeutic child care
- ❑ Out of School Time programs
- ❑ Mentoring
- ❑ Day Treatment programs
- ❑ Community-based programs and services for juvenile offenders, including:
- ❑ Outreach and Tracking
- ❑ Day Reporting Centers
- ❑ Inter-agency Intensive Supervision programs for high-risk probationers (i.e., *Safe Streets)*
- ❑ Out-of-home care:
    - ➢ Kinship and foster care
    - ➢ Therapeutic foster care
    - ➢ Group home care, general and specialized
    - ➢ Specialized Residential treatment including residential substance abuse treatment and hospital diversion/stepdown
    - ➢ Out-of-home Respite care
    - ➢ Acute psychiatric hospitalization
    - ➢ Incarceration
    - ➢ Residential alternatives to incarceration, including staff secure programs

APPENDIX F: DCYF FAMILY SERVICE REGIONAL OFFICE SERVICE AREAS AS OF APRIL 2001

As of December 2001, the RI Department of Children, Youth and Families is divided into four geographic catchment areas for ongoing child welfare case management purposes. Probation offices overlap have some overlap with these regional offices but do not have direct reporting relationships to Regional Directors, instead reporting through the probation chain-of command. Children's behavioral health cases with ongoing case management needs that have no probation or child welfare involvement are also handled by the Regional Office staff.

The four Regional Offices and communities that lie within their service areas are:

❑ **Region 1: Providence Region - City of Providence**

❑ **Region 2: East Bay Region - Newport, East Providence, Barrington, Warren, Bristol, Tiverton, Little Compton, Portsmouth, Middletown, and Jamestown.**

❑ **Region 3: South County Region - New Shoreham, Narragansett, South Kingstown, North Kingstown, Charlestown, Westerly, Hopkinton, Richmond, Exeter, West Greenwich, East Greenwich, Warwick, West Warwick, and Coventry.**

❑ **Region 4: Northern Rhode Island - Central Falls, Pawtucket, Woonsocket, Cranston, Johnston, Scituate, Foster, Glocester, Smithfield, North Smithfield, Burrillville, and Lincoln.**

APPENDIX G: COMPREHENSIVE CARE NETWORKS

Lead Agency Key Expectations

❑ Each lead agency holds the primary contract with DCYF for the management and oversight of their respective Comprehensive Care Network.

❑ Each lead agency is responsible for ensuring the effective delivery of an array of services within their contracted region to all children and families referred by DCYF **and may not refuse services or treatment for these referrals or reject any of these referrals.** Each lead agency will be required to fund specialized services not available within their Comprehensive Care Network through the established case rate.

❑ Each lead agency is expected to ensure the provision of services as proximate to the child/youths' community as possible, thereby reducing the number of children and youth placed outside of their community and allowing for the child/youth to maintain connection to their local school system.

❑ Lead agencies may provide no more than twenty-five percent (25% - based on total service dollars for the region) of direct service within their Comprehensive Care Network but may subcontract with lead agencies in other Comprehensive Care Networks for direct service programming.

❑ Each lead agency may be responsible for receiving funds for network services rendered and for the reimbursement of subcontractors.

❑ Each lead agency is responsible for measuring the performance of their respective network and the individual subcontractors of that network. The lead agency is also responsible for reporting to DCYF the results of such evaluations.

❑ Each lead agency holds the primary responsibility for care and case management functions and responsibilities.

Lead Agency Management Functions

❑ Developing a flexible network of service providers that meet identified needs of the region

❑ Providing a single point of entry to the service system

❑ Coordinating services throughout the course of treatment, placement and aftercare

❑ Working with DCYF case managers and families to develop family and child service plans

❑ Family conferencing

❑ Implementing "no reject, no eject" policies

❑ Implementing standard service definitions and common clinical protocols

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❑ Treatment planning and conducting treatment team meetings with family members and clinicians

❑ Implementing Continuous Quality improvement

❑ Collaborating with schools, law enforcement, court, medical providers and others to ensure goals and treatment needs are being met

❑ As necessary developing, implementing and evaluating written interagency agreements with LEA's.

❑ Maximizing Medicaid/SCHIP, private insurance and education funding

❑ Coordinating, reviewing and authorizing direct care providers' claims and bills for clinical and non-clinical services

❑ Submitting required reports (fiscal, performance, outcomes, etc.) to DCYF

❑ Comprehensive Care Network budget management

❑ Providing supports and services not currently funded by the current payment methodology (e.g., class trips, recreation, music lessons, tutoring, other special needs of children and families)

DCYF Regional Office functions

❑ Overseeing and participating in gate keeping into the comprehensive care networks

❑ Serving as the primary liaison to the comprehensive care networks

❑ Case management and clinical conferencing with the comprehensive care networks

❑ Monitoring day-to-day service utilization, program performance and performance indicators

❑ Participating in planning and coordinating services among the lead agency, care network providers, DCYF staff, community partners and other parties

❑ Technical assistance and training

❑ Participating in service expansion and new service development

❑ Developing network protocols and procedures

❑ Conflict resolution

❑ Regional budget management

DCYF Central Office Functions

❑ Oversight of the Comprehensive Care Network Initiative

❑ Establishing gate keeping procedures and arrangements with other state agencies (particularly DHS)

❑ Planning and developing system enhancements

❑ Developing blended funding solutions with DHS

❑ Identifying issues and trends and devising plans with other parties to address those issues and trends

❑ Participating in service expansion and new service development

❑ Developing common service taxonomy

❑ Establishing capacity to better understand Medicaid

❑ Monitoring outcomes of services

❑ Establishing reporting requirements

❑ Providing administrative support services to lead agencies and Regional Offices

❑ Establishing case rates and other funding mechanisms

❑ Oversight and monitoring of lead agency contracts in collaboration with Regional Offices

❑ Reporting to the legislature and administration

❑ Establishing and maintaining relationships with RIDE, Family Court, DHS, DOH, MHRH and key stakeholders

❑ Establishing a model for handling grievances and resolving conflicts

Comprehensive Care Network Services

❑ Preventive services

❑ Crisis intervention (available 24 hours/day, 7 days/week, 365 days/year)

❑ Initial assessment

❑ Specialized assessments (e.g., caretaker safety; sex offender; physical health, mental status and substance abuse screening, etc.)

❑ Development of family-centered family/child service plans

❑ Family conferences

❑ Day treatment and reporting

❑ Outreach and tracking

❑ Family respite

❑ Wrap-around services

❑ Behavioral health services

❑ Outpatient/community-based counseling services

❑ Outpatient substance abuse treatment

❑ Medication evaluation, management and re-evaluation

❑ Family support and parent education

❑ Parent Aides

❑ Counseling

- ❑ Home Visitation Services for Newborns

- ❑ Tutoring

- ❑ Recreation

- ❑ Transportation

- ❑ Residential services including:

  - ➢ Respite Care

  - ➢ Shelter Care

  - ➢ Regular Foster Care

  - ➢ Specialized and Therapeutic Foster Care

  - ➢ Group Homes

  - ➢ Staff Secure Residential Group Homes

  - ➢ Intensive Residential Treatment

  - ➢ Specialty Residential Treatment (i.e., sex offenders, substance abuse)

- ❑ Ability to access In-patient Psychiatric hospital services as needed through affiliation agreements with psychiatric hospitals

- ❑ Aftercare

APPENDIX H: COMPARISON CHART OF COMPREHENSIVE CARE NETWORKS/CEDARR FAMILY CENTERS/LOCAL COORDINATING COUNCILS

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Geographic Access	Specified Geographic Areas	Statewide, with requirement for local accessibility	Specified Geographic Areas
Target Population	DCYF -defined populations: ❑ delinquents ❑ in custody for abuse/neglect ❑ voluntary due to behavioral health needs requiring state assistance	Families with children with special health care needs, i.e., with condition or risk of condition requiring health or related services of a type or amount beyond that required by children generally.	Families with children at significant risk for or identified as seriously emotionally disturbed.
Presenting Needs	❑ wayward/disobedient ❑ at risk for out-of-home or out-of-community placement	Issues associated with special needs unresolved. May include: ❑ Risk for out-of-home or out-of-community placement ❑ Difficulties within family support system ❑ Need for specialty diagnosis; more information re: condition ❑ Difficulties with current services/services coordination ❑ Information /advocacy about services, resources, programs' various eligibility rules ❑ Problems associated with transitions	Emotional or behavioral challenges that significantly disrupts functioning at home, school or in community

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Family Choice	❑ Legal status - case plan driven ❑ Non-legal status - voluntary participation by families	❑ Participation by families is voluntary. ❑ Families have choice of provider.	Participation by families is voluntary.
Funding	State/Federal funding: ❑ Title XIX, IV-E ❑ Private sources ❑ Grants	State/Federal funding: ❑ Title XIX, XX, XXI ❑ Private sources ❑ Grants	State funds.
Payment Mechanism	Case rate for services.	Fee for service.	DCYF contracts.
Scope of Service	❑ Assessment ❑ Care Planning ❑ Referral ❑ Evaluation ❑ Coordination ❑ Lead agency restricted to providing no more than 25% of direct services within their Care Network	❑ Assessment ❑ Care Planning ❑ Referral ❑ Evaluation ❑ Coordination	❑ Service coordination ❑ Family Support ❑ Information, education, advocacy ❑ Non-traditional wraparound support not covered by other funding sources
Utilization Management Function	❑ State provides utilization management of Lead Agency. ❑ Lead agency is responsible for ensuring that subcontractors meet expectations.	❑ Case based data tracking. ❑ CEDARR Direct Services authorized when included in approved Family Care Plan.	None

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Services Provided	Comprehensive array of services from general outpatient to respite to residential treatment (with affiliation agreements with hospitals for psychiatric hospitalization needs). Includes case management No reject - no eject policy for Lead Agency	❑ Basic services and supports – service identification/referral, special needs resource information, system mapping/navigation, peer support ❑ Initial Family Assessment ❑ Specialty Evaluation; Treatment consultation ❑ Family Care Plan Development; periodic review and revision, service tracking ❑ Crisis Intervention ❑ Direct services to be provided only by "CEDARR Direct Service Providers"	Family Service Coordinators: ❑ meet with families to prepare for case review process ❑ assist in identifying appropriate support for parents in the team meetings ❑ coordinate and schedule team meetings ❑ support and advocate for family needs ❑ maintain documentation ❑ complete data collection requirements for system evaluation ❑ follow-up on team assignments ❑ provide community education and information ➢ The - Coordinated Children's Services System - provides for non-traditional, wraparound services through community planning teams.

	Comprehensive Care Networks	CEDARR Family Centers	LCC's

Oversight and Monitoring
➢ Certification/
➢ Accreditation
	➢ System oversight by DCYF
	➢ Lead Agency responsible for monitoring service utilization
		❑ System oversight - DHS, CEDARR Policy Advisory Committee
		❑ Certification by DHS. Oversight and Monitoring
		  ➢ Identification of key program issues
		  ➢ Comprehensive data system/data reports/analyses
		  ➢ Provider compliance w/standards
		  ➢ Service delivery process/outcomes
		  ➢ Site visit compliance reviews
			N/A

Contracting	❑ Specific contracting responsibility ❑ Specified timeframe ❑ Limited number	❑ Rolling certification of CEDARR Family Centers by DHS ❑ Certification for any applicant that demonstrates compliance with standards.	Functions contracted by DCYF.

	Comprehensive Care Networks	CEDARR Family Centers	LCC's

Data Requirements	To be defined during development process but my include, although not exclusively, the following:
	❑ DCYF - RICHIST -
	  ➤ Network referrals
	  ➤ Presenting needs
	❑ Network Data Reports -
	  ➤ Systems evaluation
	  ➤ Performance indicators
	  ➤ Outcome data
	❑ Child Welfare Performance - YALE
	  ➤ Demographic information
	  ➤ Presenting issues
	  ➤ Service needs/referrals
	  ➤ Educational Need/Performance
	❑ Placement Solutions -
	  ➤ Service utilization reports for youth placed in and out of state
	  ➤ Service plans for moving youth from high-end residential to community-based support
		CEDARR electronic case coordination system provides consistent management tool and establishes uniform centralized data base. Core data elements in such areas as:
		❑ Demographic information
		❑ Referral sources, presenting issues, other service system involvement of child/family.
		❑ Assessment of Family Care Plan components (identified strengths, needs, goals, objectives, interventions)
		❑ Process of care (timelines, completion, referrals, services received)
		❑ Service gaps experienced
		❑ Outcomes of family care plans
			Project Hope Evaluation Data Collection for youth with SED leaving RITS with aftercare support:
			❑ Demographic information
			❑ Presenting needs
			❑ Identified services, referral sources for mental health, social services, educational, operational, recreational, vocational, health and juvenile justice
			❑ Barriers to services being delivered
			❑ Child and Adolescent Functioning Assessment Scale (CAFAS)

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Collaboration - Required Partners	❑ Networks must develop as many connections and linkages to the community as possible. ❑ All subcontractors required to attend regular team meetings to review any case as necessary and appropriate. ❑ Monthly team meetings with contractors and DCYF case workers allows ability to move children, youth and families flexibly within the network up, down and across treatment levels based on the immediate needs; review standards; cross -agency training; and the collaborative planning of events.	Collaboration/coordination required with: ❑ Families ❑ LEAs ❑ LCCs ❑ Early Intervention ❑ DCYF case workers ❑ Primary physician ❑ DHS ❑ RIte Care health plan, commercial payers ❑ Other community natural supports	The voting membership of Local Coordinating Councils must include broad community representation of at least 19 participants, of which no more than 4 may be employees of the fiscal agent.
Case Management	Provided within Network; DCYF caseworker also responsible.	Not required.	Case management provided by some LCCs, but not all.

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Care Coordination		Family Care Coordination Assistance- Activities to: ❑ Support initiation of Family Care Plan –assist, help arrange for and coordinate key interventions to meet goals and objectives ❑ Promote development of family empowerment and self advocacy skills Reimbursable service by CEDARR Family Center; level of effort at 4-6 hrs/month Limited to six months duration as start of Family Care Plan; may be renewed based on need/transition.	All LCCs provide care coordination.

APPENDIX I: DCYF RECOMMENDATIONS TO THE JOINT LEGISLATIVE COMMISSION TO STUDY AN ENHANCED ROLE FOR PROBATION AND PAROLE (MARCH 2001)

ADMINISTRATION AND MANAGEMENT

- ❑ Enhance services for young women offenders
- ❑ Develop standards based on American Probation and Parole Association (APPA) Best Practices
- ❑ Establish curriculum for staff training and development
- ❑ Implement continuous quality improvement process
- ❑ Utilize computer mapping to identify geographic "hotspots" based on probationer and criminal activity

COMMUNITY SUPERVISION

- ❑ Study feasibility of one probation counselor for each youth throughout the system
- ❑ Re-validate the current risk assessment tool
- ❑ Develop comprehensive assessment component
- ❑ Develop case profiles
- ❑ Establish contact standards
- ❑ Establish caseload forecasting model
- ❑ Review assignment of offenders to probation caseload
  - ➢ transfer policy between probation counselors and DCYF social caseworkers
  - ➢ convicted adults in Family Court
  - ➢ transition from RI Training School to probation

COMMUNITY SERVICE AND SUPPORT

- ❑ Expand community support service system:
  - ➢ Outreach and tracking
  - ➢ Gang intervention
  - ➢ Mentoring
  - ➢ Substance abuse counseling
  - ➢ Sex offender monitoring and treatment
  - ➢ Employment services
  - ➢ Family support services
  - ➢ Mental health counseling
- ❑ Enhance early intervention and transitional services for young women offenders

STAFF RECRUITMENT AND TRAINING

❑ Formalize current outreach efforts to recruit minority probation counselors

❑ Negotiate a modified civil service exam

❑ Develop core staff training curriculum specifically tailored for juvenile probation and parole staff

  ➢ New staff = 120 hours in first year

  ➢ Veteran staff = 40 hours annually

COMMUNITY PARTNERSHIPS AND LINKAGES

❑ Expand information sharing and collaboration with police departments throughout the state

❑ Expand *Safe Streets* model to all five (5) core cities

❑ Expand Day Reporting Centers to all five (5) core cities

❑ Support the continued development and enhancement of Juvenile Hearing Boards

❑ Support the expansion of Juvenile Drug Courts and Truancy Courts within agreements outlining roles and responsibilities between DCYF and the Family Court as to case management and service delivery functions

CASELOAD MANAGEMENT

❑ Achieve target caseloads as follows

  ➢ Probation supervisor to probation counselor: 1:8

  ➢ Probation caseload: 30:1 (Current = 41:1)

  ➢ Parole caseload: 35:1 (Current = 47:1)

  ➢ *Safe Streets* caseload: 15:1 (Current = 17:1)

APPENDIX J: LISTING OF LICENSED AND BOARD CERTIFIED PROFESSIONALS

Licensed Psychiatrist, Board Certified (American Board of Medical Specialties) in Child and Adolescent Psychiatry (M.D.)

Licensed Psychologist (Ph.D./Psy.D.)

Certified Registered Nurse Practitioner (CRNP)

Licensed Independent Clinical Social Worker (LICSW)

Licensed Clinical Social Worker (LCSW)

Licensed Marriage and Family Therapist (LMFT)

Licensed Mental Health Counselor (LMHC)

Licensed Chemical Dependency Counselor

Licensed Practical Nurse (LPN)

Registered Nurse (RN)

Licensed Physician Assistant (PA)

Certified Nursing Assistant (CNA)

APPENDIX K: PERFORMANCE MEASURES AND OUTCOMES FOR THE SYSTEM OF CARE

THREE FORMS OF MEASUREMENT

Context Evaluation

Context evaluation focuses on assessing the needs, assets, and resources of the state and local communities in order to plan relevant and effective interventions within the context of the community. It also identifies the political atmosphere and human services context of the community to increase system design support by community leaders and local organizations.

Implementation Evaluation

Implementation Evaluation addresses a broad array of elements. The purpose of this type of evaluation in Rhode Island's System of Care include:

❑ Identifying and maximizing strengths in development

❑ Identifying and minimizing barriers to implementing activities

❑ Determining if project goals match target population needs

❑ Assessing whether available resources can sustain project activities

❑ Measuring performance and perceptions of the staff and children, youth and families

❑ Documenting systemic change.

Outcome Evaluation

Assessing outcomes employs five levels of measurement:

❑ Individual child and family outcomes –individualized assessments for a specific client

❑ Program measures (outcomes of a group of children, youth and families receiving specific services)

❑ Agency or departmental indicators (results of all children, youth and families served by an agencies services)

❑ System-wide data (child serving system data from multiple agencies)

❑ Community population statistics (a description of the wider community demographics)

In the System <u>of Care,</u> the development of the outcome evaluation builds on the work completed to date by state agencies in developing common outcomes to use across the system. This process involves stakeholder participation to determine what outcomes are expected or hoped for and to think through how individual participant/client outcomes connect to specific program or system level outcomes. These outcomes measures:

❑ Help answer questions about what works, for whom, under what conditions and how to improve program delivery and service

❑ Determine which implementation activities and contextual factors are supporting or hindering outcomes and overall program effectiveness

❑ Demonstrate the effectiveness of the system and make the case for its continued funding.

A formative evaluation approach is used integrating evaluation processes into the routine operation of service provision. In the System of Care, evaluations develop useful, accessible findings that bridge the gap between research and practice, informing decision-making and improving service programming. It shifts the focus from outputs to results –from how a program operates to the good it accomplishes[26].

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[26] Stroul, 1993/Woodbridge and Huang, 2000.

Performance Measures and Outcomes - Recommendation 1: The Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of this plan must include families (parents, kin, foster and adoptive families.

Overview -

Department(s)	Action Steps – Year 1-2	Indicators - Establish Baseline In Year 1	Data Sources	Performance Measures – Year 2-5	Outcomes - Year 2-5
Within the Children's Cabinet - DCYF DHS RIDE DOH MHRH	❑ Establish MOA for Implementation Team with identified funding resources. ❑ Assign key staff. ❑ Establish implementation milestones and schedule.	❑ **Identify relevant** ❑ **percentage of service** ❑ **utilization for tracking -** ❑ Utilization of prevention services ❑ Utilization of emergency services ❑ Utilization of health plan child/family services ❑ Utilization of HBTS (EPSDT)	❑ DHS - ➤ Rite Care ➤ HBTS (EPSDT) ➤ CEDARRs ➤ Medicaid FFS expenditures ❑ DCYF - RICHIST: children/youth receiving of out-of-home mental health or therapeutic tx services	❑ Data infrastructure operational. ❑ Data elements being shared, trends tracked. ❑ Systems alignment evolving. ❑ Services accessed. ❑ Waiting lists reduced/eliminated.	❑ **Compare with Year 1 - baseline data** ❑ Prevention service capacity - expected increase ❑ Emergency services care- expected decrease ❑ Community-based support - expected increase ❑ Court referrals - expected decrease

Overview (continued)

Department(s)	Action Steps – Year 1-2	Indicators - Establish Baseline In Year 1	Data Sources	Performance Measures – Year 2-5	Outcomes - Year 2-5
	❑ Identify data elements within each Department and create reporting formats and schedule. ❑ Report quarterly. ❑ Establish protocols to address systems' barriers. ❑ Establish action plan(s) for necessary adjustments. ❑ Design Community Prevention Partnerships	❑ Utilization of IEPs ❑ Utilization of community-based support ❑ Utilization of out-of-home placement ❑ Utilization of out-of-district placement ❑ Utilization of psychiatric hospitalization ❑ Utilization of out-of-state placement ❑ Agency/service specific data on community level	❑ DOH – ➤ Early Intervention ❑ RIDE – ➤ IEP Services ➤ Private Special Education Schools ❑ MHRH – ➤ Substance Abuse ➤ Adult MH ➤ DD Services	❑ Service gaps/needs identified and addressed with new service development; targeted capacity enhancement. ❑ Community trends: ➤ school attendance ➤ school performance ➤ school suspensions ➤ expulsion rates ➤ arrests ➤ detention rates ➤ placement out of community rates	❑ Psychiatric hospital care - expected decrease ❑ Out-of-state placements - expected decrease

RECOMMENDATION 1 -   Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of the evaluation/accountability plan must include families.

Implementation Process -

Action Steps	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Task Force issues final report including Implementation Plan ❑ Implementation Plan elaborated and refined including: ➢ action steps ➢ responsible parties ➢ timelines ❑ Governor and Assembly designate Children's Cabinet to monitor Implementation Plan. ❑ MOA for Implementation Project with identified funding resources.	**Within 3 months of Report Issuance:** ❑ Children's Cabinet agrees to Implementation Project. ❑ A cost analysis is conducted across Departments to determine current capacity for data collection/analysis and budget needs for a comprehensive MIS infrastructure. ❑ MOA is developed and signed. ❑ Family participation is identified and accommodated. ❑ Project staff are assigned. ❑ Implementation goals are set. ❑ Budget requests are developed for future investment in data management/analysis.	Monitor key indicators for investment shift from high-end service to less restrictive and community-based care.	Monitoring implementation continues with Children's Cabinet.	Implementation and monitoring process ongoing.	Implementation and monitoring process ongoing.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Identify data elements within each Department and create data reports that are needed.	**Within 6 months of Report Issuance:** ❑ Each Department identifies the current set of data files for relevant services. ❑ The necessary programs are written for data exchange and compilation that will allow for comprehensive profile of service delivery and access needs. ❑ Identify the data elements that are necessary, but need to be developed. ❑ Create infrastructure to establish baseline data.	❑ Infrastructure is in place and operational. ❑ Needed data elements are developed within the information systems.	New data elements are reported and tracked as part of overall trend and benchmarking analysis.	Continued refinement of data elements as need is identified.	Continued refinement of data elements as need is identified.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Protocols established to address systems' barriers.	**Within 6 months of Report Issuance**: ❑ Children's Cabinet creates a workgroup of staff attorneys, information systems specialist and program staff to identify existing statutory requirements and authorities within each Department. ❑ Workgroup identifies where the statutory authority assists or impedes implementation and recommends necessary accommodations. ❑ Cabinet determines necessary action to remove systems barriers.	❑ System alignment is assessed and necessary changes are made to facilitate seamless service delivery at state and community level. ❑ Waiting list trends are reported as they relate to service access and delivery performance. ❑ Community-based trends are analyzed for local level performance measure achievements.	Ongoing assessment of systems' coordination and necessary adjustments are made.	Ongoing assessment of systems' coordination and necessary adjustments are made.	Ongoing assessment of systems' coordination and necessary adjustments are made.
❑ Information reported quarterly.	❑ Initial data compilation begins among between Departments within the first six months of project implementation. ❑ Baseline data track is established for all elements collected.	❑ Data elements are tracked regularly for trend analysis. ❑ Indicators in service areas across Departments are analyzed. ❑ Problem areas are identified.	❑ Service utilization and cost trends are analyzed quarterly. ❑ Trends represent service concentration in levels of restrictiveness/ community-based care and prevalent geographic utilization.	Data collection and analysis is ongoing.	Data collection and analysis is ongoing.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Action plan(s) for necessary adjustments.	❑ Focus on systems needs. ❑ Focus on service and program needs.	❑ Correction plans are developed as necessary. ❑ Service gaps and capacity needs are identified. ❑ Strategies are devised to address service needs.	❑ Ongoing service development and capacity building is monitored and assessed. ❑ Plans developed for increasing/changing service capacity.	Services increased or changed to meet identified population needs.	❑ Monitoring and adjustments are ongoing. ❑ Children/ families are receiving appropriate services in timely manner.

The Department of Children, Youth and Families - System Enhancement

The Department of Children, Youth and Families represents an integrated System of Care comprised of Child Welfare, Children's Behavioral Health and Juvenile Corrections. The Department's five goals for the System of Care Capacity Development are broad, but inclusive of the Department as a whole, interconnecting with each of the distinct operating divisions. The Divisions function both separately and together to provide a full array of services and programs to meet the needs of children, youth and families.

The performance measures themselves are tailored to the specific operations within the department, as part of the department's overall goals to improve the system capacity.

Performance Measures and Outcomes - Recommendation 2: DCYF must develop and implement a work plan that is geared to measure: (a) progress in continuum of care development and (b) the effectiveness of the interventions ascribed to the system.

The information gathered must also be distributed for public accountability and to identify problems and make adjustments to improve system design.

Performance Measures and Outcomes - Recommendation 2: DCYF must develop and implement a work plan that is geared to measure: (a) progress in continuum of care development and (b) the effectiveness of the interventions ascribed to the system.

The information gathered must also be distributed for public accountability and to identify problems and make adjustments to improve system design.

DCYF System of Care Capacity Development	Year 1	Year 2	Year 3	Year 4	Year 5
Goal 1: Create a community-based, family-centered service system **Goal 2: Establish a continuum of high quality, culturally relevant <u>and gender specific</u> placement resources in proximity to each child's home by expanding and improving Rhode Island in-state system of care** **Goal 3: Promote adoption/guardianship as a permanency option when reunification is not achievable** **Goal 4: Transition all children and youth from public supported care with the supports, skills and competencies in place to ensure stability and permanency.** **Goal 5: Enhance the capacity of employees, foster parents and providers to deliver high quality care to children and families.**	❑ Begin to implement Family-Centered Practice ❑ Implement concurrent planning for children in substitute care ❑ Begin implementation of Care Management Team (CMT) community-based placement mechanism ❑ Increase in-state residential capacity ❑ Continue utilization review management ❑ Establish first Regional-based Network ❑ Enhance opportunities and preparation for older youth leaving state care ❑ Enhance training and support for substitute care providers ❑ Enhance training and support for staff	❑ Phase-in of Family-Centered Practice continues ❑ Increase hospital step-down capacity in-state ❑ Establish CMT in all DCYF Regions ❑ Expand Regional Networks ❑ Monitor concurrent planning activity and adjust as necessary ❑ Continue to identify and implement training and support services	❑ Family-Centered Practice ongoing ❑ Assess and maintain hospital step-down capacity ❑ Assess and modify CMT operation as necessary ❑ Expand Regional Networks ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Family Centered Practice Ongoing ❑ Full array of treatment services available through regionally-based networks – except secure corrections and psychiatric hospitals ❑ Children and families receive appropriate care when needed ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Maintain according to plan ❑ Maintain according to plan ❑ Maintain according to plan ❑ Assess and adjust as necessary

DCYF System of Care Performance Measures	Year 1	Year 2	Year 3	Year 4	Year 5
Reform Priority Measures - ❑ Eliminate night to night ❑ Eliminate medically unnecessary days in psychiatric hospitals ❑ Reduce out-of-state purchase of service (POS) placements	❑ Reduce number of medically unnecessary days ❑ Increase family support services[27] ❑ Night-to-night Placement eliminated	❑ Reduce number of Wayward/Disobedient placements ❑ Eliminate medically unnecessary days	Continue to monitor and adjust system functioning as necessary	Continue to monitor and adjust system functioning as necessary	Continue to monitor and adjust system functioning as necessary

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[27] Family Support Services includes parent aide, home visiting for newborns, substance abuse treatment, and mental health treatment for parents

DCYF System of Care Performance Measures (continued)	Year 1	Year 2	Year 3	Year 4	Year 5

Child Welfare -
 	
Safety
❑ Reduce recurrence of child abuse and/or neglect
❑ Reduce the incidence of child abuse and/or neglect in foster care
 	
Permanency
❑ Increase permanency for children in foster care
❑ Reduce time to reunification without increasing re-entry
❑ Reduce time in foster care to adoption
❑ Increase placement stability
❑ Reduce placements of young children in group homes or institutions
 	
Well-being
❑ Educational attainment
❑ Families report improvements in
❑ parent/child interaction
❑ Chafee Foster Care Independence Measures[28]
  ➤ Improved/satisfactory grades
  ➤ improved/satisfactory school attendance
  ➤ Classroom stability improved
	❑ Enhance recruitment of foster care and adoptive parents
	❑ Reduce number of children/youth free for adoption who are not adopted
	❑ Increase annual number of adoptions from state care
	❑ Enhance staff competence with regard to preparing children and families for permanency
	❑ Reduce number of times children/youth disrupt from placements
	❑ Reduce number of children removed from home or foster care placements.
	❑ Develop "well-being" data elements.
		❑ Increase number foster care providers and therapeutic foster care providers
		❑ Assess and adjust as necessary
		❑ Assess and adjust as necessary
		❑ Ongoing training
		❑ Assess and adjust as necessary
		❑ Assess and adjust as necessary
		❑ Begin tracking "well-being" indicators
			❑ Continue recruitment and training activities
			❑ Assess and adjust as necessary
			❑ Assess and adjust as necessary
			❑ Assess and adjust as necessary
			❑ Assess and adjust as necessary
			❑ Assess and adjust as necessary
			❑ Assess trends and address needs as appropriate
				❑ Assess and adjust as necessary
				❑ Assess and adjust as necessary
				❑ Assess and adjust as necessary
				❑ Assess and adjust as necessary
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					❑ Assess and adjust as necessary

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[28] Chafee Foster Care Independence Program Measures included in Appendix K.

DCYF System of Care Performance Measures (Continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Children's Behavioral Health - ❑ % of children receiving appropriate level of behavioral health service as needed ❑ % of children still not receiving appropriate level of behavioral service as needed ❑ % of children admitted into a psychiatric hospital who remain for 21 days or less ❑ Consumer satisfaction rate for Department funded psychiatric hospital and community-based services	❑ Establish baseline for service needs including extent of waiting lists ❑ Assess and redesign as indicated - outpatient services ❑ Restructure CIS services ❑ Reduce hospital recidivism rates ❑ Assess adequacy of psychiatric hospital stepdown programs ❑ Enhance community-support capacity ❑ Increase provider rates where insufficient	❑ Assess and revise based on performance measures ❑ Implement outpatient services design ❑ Continue enhancement of community-support capacity	❑ Monitor and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary

DCYF System of Care Performance Measures (Continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Juvenile Corrections - ❑ Performance measures covering five broad areas in Security, Order & Safety; Programming; Health; Mental Health; and Justice are included in the National Performance-based standards for Juvenile Corrections of which the RITS is a partner (see Appendix K) ❑ % of adjudicated and detained RITS youth passing GED exams ❑ % of adjudicated RITS youth admitted during the fiscal year after release within the prior 12 months ❑ % of former adjudicated RITS youth who have temporary community assessment revoked	Monitoring of indicators and performance measures continues	Monitoring of indicators and performance measures continues	Assess and adjust as necessary	Assess and adjust as necessary	Assess and adjust as necessary
Provider Performance Measures - Developed in partnership with Yale University - necessary training for data collection ongoing	Data collection and analysis continues - adjustments as necessary	Data collection and analysis continues - adjustments as necessary	Assess and adjust as necessary	Assess and adjust as necessary	Assess and adjust as necessary
Workforce Cultural Competency Performance Measures Quality and Executive Capacity Initiatives	To be developed during first year	Workforce initiatives implementation prioritized and phase-in workplan established.	Workplan implementation continues	Assess and adjust as necessary	Assess and adjust as necessary

Rhode Island DCYF Child Welfare Performance Measures

CES	Early Start	Family Preservation	Outreach and Tracking	Youth Diversionary	Residential, Shelter, Foster Care
# of families reported for abuse or neglect during reporting period					
		For children with goal of home preservation, # of children at home			
		For Children with goal of reunification, # of children reunified			
			# of children who go into out of home placements and # that are planned placements		
			# of children with new charges or adjudication		
# of families with improved/stable parenting skills (North Carolina Assessment Instrument)	# of children assessed w/subtypical development in any area of Ages to Stages				# of children with improved adaptive functioning scores (GAF) (Ages 4 and over)
# of families where the risk of abuse/neglect has decreased/ remained low (North Carolina Assessment Instrument)	# of children who have achieved new developmental milestone (Ages to Stages)				
# of families with changes in each of the domains (North Carolina Assessment Instrument)	# of children with subtypical development in one or more domains who showed improvement in that domain from previous Ages to Stages assessment				

Rhode Island DCYF Child Welfare Performance Measures (continued)

CES	Early Start	Family Preservation	Outreach and Tracking	Youth Diversionary	Residential, Shelter, Foster Care
	# of families showing improvement (Selected Child Well Being Scale				
	# of families with reduction of stress (Parenting Stress Index-Short Form)				
			# of adolescents who received their GED during reporting period		
			# of adolescents who received their HS diploma during reporting period		
			# of children/youth with improved/satisfactory grades		
			# of children/youth with improved/satisfactory school attendance		
			# of children/youth whose classroom stability improved		
			# of children/youth with time out of school (detentions; suspensions; expulsions)		
			# of children/youth with in-school (detentions, suspensions)		

PERFORMANCE-BASED STANDARDS FOR JUVENILE CORRECTION AND DETENTION FACILITIES

I. SECURITY, ORDER AND SAFETY

A. Security

1) Completed and uncompleted escapes, walk-aways and AWOLs per 100 person-days of youth confinement

2) Incidents involving contraband (weapons, drugs and other forms) per 100 pers0n-days of youth confinement

B. Order

1) Major misconduct by youth per 100 person-days of youth confinement

2) Staff involvement in documented misconduct per 100 staff-days of employment

3) Physical restraint use per 100 person-days of youth confinement

4) Mechanical restraint use per 100 person-days of youth confinement

5) Use of isolation and room confinement per 100 person-days of youth confinement

6) Average duration of isolation and room confinement

7) Percent of idle waking hours (i.e., hours when there is no scheduled program or activity

C. Safety

1) Injuries to staff per 100 staff-days of employment and to youths per 100 person-days of youth confinement

2) Suicidal behavior by youth per 100 person-days of youth confinement

3) Percent of days during the assessment period when population exceeded design capacity by 10 percent or more

4) Youths injured during the application of physical, mechanical and chemical restrains per 100 person-days of youth confinement

5) Assaults on youth and staff per 100 person-days of youth confinement

6) Percent of staff and youth who report that they do not fear for their safety

II. PROGRAMMING

A. Improve education and vocational competence

B. Provide an educational program that is tailored to each youth's education level, abilities, problems and special needs and that improve education performance and vocational skills while confined.

1) Youths reading and math scores of admission, every 90 days and at discharge for youths confined more than 90 days

2) Percent of youth who report that they received education while in isolation

C. Provide vigorous programming that is culturally competent and gender specific, that minimizes periods of idle time, that addresses the behavioral problems of confined youth and that promotes healthy life choices.

1) Percent of youth whose records indicate they have received a health assessment

2) Percent of youth whose records indicate they have received a mental health assessment

3) Percent of youth whose records indicate they have received a substance abuse assessment

4) Percent of youth whose records indicate they have received reading and math tests

5) Percent of youth whose records indicate they have received a social skills assessment

6) Percent of youth whose records indicate they have received a vocational assessment

7) Percent of youth whose records indicate they have received a physical fitness assessment

8) Percent of youth confined for more than 60 days whose records include a written individual treatment plan

9) Percent of youth confined for more than 60 days whose records indicate that they received the education programming prescribed by their individual treatment plans

10) Percent of youth confined for more than 60 days whose records indicate that they received the social skills programming prescribed by their individual treatment plans

11) Percent of youth confined for more than 60 days whose records indicate that they received the vocational skills programming prescribed by their individual treatment plans

12) Percent of youth confined for more than 60 days whose individual treatment plans have monthly progress notes

13) Percent of youth continued for more than 1 year whose records include an annual summary of treatment progress

14) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed the health curriculum

15) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed a social skills curriculum.

16) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed a vocational skills curriculum

17) Percent of youth interviewed who report receiving at least one hour of large muscle exercise each day on weekdays and two hours each day on weekends

18) Percent of interviewed youth who report receiving education materials while in isolation

D. Promote continuity in programming and services for youth after they are released

1) Percent of released youth who were confined for more than 60 days whose reintegration plans address the remaining elements of their individual treatment plans

E. Open facility to the community via telephone, visitation and volunteer involvement.

1) Percent of youth who report that policies governing telephone calls are implemented consistently

2) Percent of youth who report that they have placed and/or received telephone calls from a parent or guardian

3) Visitation per 100 person-days of youth confinement

4) Percent of youth getting visits

5) The number of community volunteers providing programming in the facility

6) The number of different programs that engage community volunteers

III. HEALTH AND MENTAL HEALTH

A. Identify youths at time of admission who have acute health problems or crisis mental health situations and following evaluation, ensure delivery of appropriate health or mental health services.

1) Percent of staff completing training in administering the health and mental health intake screening who passed a competency test at the end of the training

2) Percent of youth presented for admission who have a health and mental health intake screening completed in one hour or less

B. Provide health appraisals for all youth not released quickly, as well as behavioral, mental health and substance abuse evaluations where indicated.

1) Percent of youth presented for admission whose health assessments were completed within seven days, or sooner as required by law

2) Percent of youth presented for admission whose health assessments were completed within seven days, or sooner as required by law

3) Percent of youth needing a substance abuse assessment for whom it was completed within 14 days of admission or within 14 days of referral

C. Develop or continue individual treatment plans for each confined youth to respond to health, mental health, substance abuse or behavioral problems.

   1) Percent of youth confined for more than 30 days whose records include a written individual treatment plan

   2) Percent of youth confined for more than 60 days whose records indicate that they received the health treatment prescribed by their individual treatment plans

   3) Percent of youth confined for more than 60 days whose records indicate that they received the mental health treatment prescribed by their individual treatment plans

   4) Percent of youth confined for more than 60 days whose records indicate that they received substance abuse treatment prescribed by their individual treatment plans

D. Respond in an appropriate and timely manner to the new and chronic health and mental health problems of youth in confinement.

   1) Percent of youth who report receiving at admission written and oral instructions for obtaining health, mental health and substance abuse care.

   2) Average duration between when youths filed a sick call request and the time they were seen by health care personnel, qualified counselors or mental health care providers

   3) Percentage of youth whose records indicated that they required urgent off-site medical services who received the services in less than an hour

E. Promote continuity of treatment for youth undergoing treatment at the time they leave the facility.

   1) Percent of youth undergoing treatment for a chronic or acute illness, injury or medical condition at the time of their release who have arrangements for continuation of treatment in their reintegration plans

   2) Percentage of youth undergoing treatment for a mental health problem at the time of their release who have arrangements for continuation of treatment in their reintegration plans

   3) Percent of youth undergoing treatment for substance abuse problem at the time of their release who have arrangements for continuation of treatment in their reintegration plans

F. Provide a clean and healthy environment where confined youth are safe and ensured adequate nutrition and exercise.

   1) Percent of youth whose records indicate that they have been abused or neglected by staff

   2) Injuries to youth from (a) other youth and (b) staff per 100 person-days of youth confinement

3) Incidents of suicidal behavior per 100 person-days of youth confinement

IV. JUSTICE

A. Operate the facility in a manner consistent with applicable regulatory, statutory and case law requirements.

1) Grievances or complaints filed per 100 person-days of youth confinement, or per 100 staff-days of employment

2) The percent of interviewed staff and youth who filed a grievance or complaint who received a hearing

B. Ensure that youth, their custodians and other appropriate parties know their legal rights and how to protect them.

1) Youth understand facility rules and their legal rights

2) youth know how to pursue their legal rights

C. Administer the rules and policies for staff and youth fairly and consistently and offer effective means of redress of grievances or violations of rights.

1) Percent of interviewed youth who believe that grievances are fairly, consistently and effectively redressed.

D. Provide confidential and reasonably prompt communications between youth and their lawyers and to make youth available for legal or administrative proceedings.

1) Percent of youth who report that they have timely and reasonable access to their attorneys when requested

2) Attorney visits per 100 person-days of youth confinement

3) Percent of person-days of confinement during the assessment period attributable to missed hearings or administrative proceedings

John H. Chafee Foster Care Independence Program

Draft Performance Measures

❑ Performance Measure 1: Increase the percentage of youth who have resources to meet their living expenses.

❑ Performance Measure 2: Increase the percentage of youth who have a safe & stable place to live.

❑ Performance Measure 3: Increase the percentage of youth who attain educational (Academic or Vocational) Goals.

❑ Performance Measure 4: Increase the percentage of youth who have positive personal relationships with adults in the community.

❑ Performance Measure 5: Increase the percentage of youth who avoid involvement with high risk behaviors.

❑ Performance Measure 6: Increase the percentage of youth who are able to access needed physical and mental health services.

❑ Performance Measure 7: Increase the percentage of youth who have or know how to obtain essential documents.

APPENDIX L: REPORT OF THE FOSTER CARE RECRUITMENT AND RETENTION COMMITTEE OF THE RHODE ISLAND SYSTEM OF CARE TASK FORCE (MARCH 2002)

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5.) Appendices: The following appendices are available in hardcopy upon request: Financial Effects of Recommendations; Foster Care Pre-service curriculum; Foster Care Services Organizational Chart; Foster Care Flowchart; Sample Retention Survey

INTRODUCTION

I want to begin by thanking Dr. Robert Carl, Director of the Department of Administration for the opportunity to serve on the Rhode Island System of Care Task Force and to chair the Foster Care Recruitment and Retention Committee. As the Executive Director of CHisPA, the Center for Hispanic and Policy Advocacy, whose mission is **to lead and influence change that improves the quality of life for Latinos in Rhode Island,** this initiative interested me as a challenge in light of the numbers of children of color who are in the DCYF system.

The goals of the Foster Care Recruitment and Retention Committee were: to identify the strategies, strengths, and challenges associated with DCYF's efforts toward increased recruitment of foster families to provide safe, nurturing homes for children in the care of the State. To Enhance tracking, monitoring and support systems to maximize retention of foster parents.

The work of this task force and subcommittee has great implications for the future of our children**.** I want to thank the members of the Foster Care Recruitment and Retention Committee for their commitment to this goal and the overall process, which ensured an analysis of the foster care system and policy recommendations. This report is testament to months of hard work and dedication resulting in data, overview of the foster care system and recommendations that are both practical and realistic.

It is you, the reader, who can ensure that these recommendations are implemented and that collectively we work to continue to improve our system. We welcome your feedback by e-mailing comments to Paula Fontaine at FontaiP@dcyf.state.ri.us by March 9, 2002.

Thank you for your support,

Luisa C. Murillo

Chairwoman,
Foster Care Recruitment and Retention Committee

<u>*GOAL STATEMENT:*</u>

To identify the strategies, strengths, and challenges associated with DCYF's efforts toward increased recruitment of foster families to provide safe, nurturing homes for children in the care of the State. To Enhance tracking, monitoring and support systems to maximize retention of foster parents.

<u>OVERVIEW OF FOSTER CARE RECRUITMENT, TRAINING, LICENSING AND THE PLACEMENT PROCESS WITHIN DCYF</u>

Recruitment:

Recruitment is done by one individual in the department at this time. This person is responsible for advertising, Public Relations, Information meetings, Community Recruitment, and is the Liaison with The RI Foster Parent Association. This individual responds to all inquiries, processes initial applications, including references, BCI and DCYF clearances. The Department's Recruiter position reports directly to the Chief of Contracts and Standards, Division of Community Resources.

Effective recruitment of Foster Parents is essential to the Safety, Permanency and Well Being of children in the care of The State. The Department needs to increase ability to recruit minority foster parents as well as foster parents who will care for older children.

Pre-Service Training:

In July of 2000, in response to recommendations made by the 1999 Governor's Commission to Study the Placement of Children in Foster and Adoptive Care, the Department consolidated staff who train foster and adoptive families. A second Clinical Training Specialist was added to the staff to train foster parents at that time. A Chief Casework Supervisor was hired in June, 1999 to coordinate these efforts. The restructuring and enhancement of the unit has allowed us to eliminate unnecessary waiting lists for foster parent training. Since January of 2001, training of Foster Parents has been done by two full time Clinical Training Specialists. There have been 8-10 classes held per year, each class being 9 weeks in length. Classes have been held in Providence, North Kingstown and Woonsocket. A Foster Parent co-leads the groups. Foster Parent training staff have been included in a unit composed of staff who recruit, train and provide ongoing support to Visiting Resource and Adoptive Resource Families. These positions report to the Chief of Adoption and Foster Care Preparation and Support in the Division of Child Welfare. As of January, 2001, all foster parents are trained in Concurrent Planning theory and practice. This was also in response to the 1999 Governor's Commission.

 In January, 2002, Foster Parent and Adoptive Parent training was consolidated. This will allow for a substantial increase in the numbers of foster parents trained in one year, and will further cut down on waiting periods to begin the training process. Dual training will also enhance the training experience for all families, better preparing them for the issues they may face in the future-e.g., foster families will be better prepared to make the transition to

adoption and lifelong commitment, while adoptive families will be better prepared to deal with issues of visitation or work with birth families in open adoption situations.

Licensing:

Foster Care Licensing is administered by the Licensing Administrator in the Division of Community Resources. There is one Supervisor and 8 Licensing workers. There are two fire inspectors. This unit processes all completed applications received from the Foster Parent recruiter as well as Kinship and Child Specific applications received from Family Services staff. This unit completes the licensing process assuring that licensing requirements have been met, including fire inspection, physician's references, DCYF and criminal clearances, and the writing of a home study.

Placement:

The Placement Unit consists of 3 Workers and a Supervisor who are responsible for the daily requests for placements. These workers maintain a listing of available placements including foster homes, shelter and group homes. As requests for placements come in, placement unit workers attempt to match the children with the best available resource. Workers develop close working relationships with foster families and DCYF line staff. The Placement Unit Supervisor reports to The Chief of Contracts and Standards, Division of Community Resources.

Retention:

In 1998 The Department hired a full time Foster Parent Liaison. This individual responds to Foster Parent concerns and complaints as well as provides mediation services between DCYF staff and Foster Parents. The position has proven successful in improving communication between DCYF and the Foster Parent community as well as preserving placements for children. This position reports to the Chief of Development, Contracts and Standards, in the Division of Community Resources.

Link to Adoption:

Approximately 75-80% of DCYF adoptions occur with foster parents adopting children in their care. Pre-adopt parents are increasingly taking placement of children who are "Legal Risk", thus the need to license these homes as foster placements.

Department staff who are involved with any aspect of foster or adopt services participate in a monthly in house meeting devoted to improving communication and enhancing services to our families who care for our children. This has been a successful process and has improved communication between divisions.

Due to the numbers of Foster Parents who adopt, the need for post adopt education and support is critical. The Department houses an Adoption Services Unit whose job largely entails post adoption service/ resource referral. Although there has been an increase in these workers meeting with families to assess needs and provide direct service and support, there is not sufficient staff in the Adoption Services Unit to meet the possible   needs of the 2500 (and

growing) families who currently receive subsidy.

FOSTER PARENT RECRUITMENT

Current

Recruitment activities focus on both the long term process of increasing general public awareness of the role of foster parents and the licensing process and the immediate need for increasing our available pool of qualified foster parents. Towards these goals, the following activities are undertaken: Print Advertising – aimed at reaching both general and targeted populations of prospective foster parents, throughout the state through 33 daily, weekly, monthly, and special interest publications; Radio Advertising; Television Advertising; Recruitment Events – Informational Booths and Presentations; Informational Meetings; Targeted Recruitment Efforts – directed at reaching specific populations, such as minority groups, pediatric nurses, and potential foster parents for specific groups of children, such as developmentally disabled children, medically fragile children, and adolescents with foster parent recruitment materials.

These combined activities resulted in the following outcomes for FY2001: **762** inquiries (applications mailed out); **141** completed applications returned; and **118** applications submitted to Licensing for Assignment/Review,(of whom **25%** were minority applicants: **18%** African American; **7%** Latino.) During the year ending 12/31/00, **178** generic foster homes were licensed; in the 2 ½ year period 1/99 - 6/01, **413** new generic foster homes were licensed.

The Department's recruitment effort is best viewed as a multi-year plan since it will take time for the initial gains to become evident. Both general and targeted recruitment activities are essential to meet our goal. General recruitment will reach a broad range of families interested in the spectrum of children we have available for placement. Targeted recruitment will allow us to direct our appeals to specific groups, including ethnic minorities: African Americans, Latinos, and Southeast Asians; foster parents for special needs children, including drug exposed infants; medically fragile / technologically dependent children; sibling groups; the developmentally disabled, and adolescents.

What conclusive research recruitment exists strongly suggests that the approval of a significant number of quality foster homes results from on-going and diverse activities that maintain a positive awareness of foster care over at least one year's time. It has been noted that individuals think about becoming foster parents for about one full year before they actually contact an agency. Constant exposure, over an extended period of time, to the idea of becoming a foster parent will stimulate thought and result in making an inquiry call.

Responsibilities

Presently, the Department employs one full-time foster parent recruiter. The recruiter is responsible for developing a foster parent recruitment plan including general and targeted recruitment goals; developing print and media advertising campaigns; conducting community education and public awareness activities; responding to foster parent inquiries; processing of submitted foster parent applications and background checks; referral of completed application

packets to Licensing Division for assignment / review; developing, implementing, and monitoring the service contract with the Rhode Island Foster Parents Association.

The goal of foster parent recruitment is to ensure that sufficient numbers of qualified foster families are available to meet the needs of the Department and the children it serves and to allow for careful matching and planned placements which meet the best interests of every child in need of foster care. As approximately 80% of all DCYF children who are adopted are adopted by their foster parents, it is critical that initial foster placements be conducted with consideration to a child's long term needs. For the purpose of this plan, we will concentrate our focus upon the need for generic foster homes.

Public Awareness Campaign

Community education is absolutely essential to recruitment. The public must be educated about foster care, the ever increasing need for capable foster parents, and the important role foster parents play in the child welfare service delivery system. People do not offer to do things they neither recognize or understand. Foster care issues must be brought before the public regularly and repeatedly, and the Department must strive to create and maintain a positive awareness of foster care. The efforts of the Rhode Island Foster Parents Association need to be enlisted in this venture. Additionally, professionally produced public relations materials are critical to a successful campaign. Print, radio, and television advertising play an important role in communicating the need for foster parents for both general and targeted populations

The Department needs to recruit families who are capable and willing to perform the functions that the agency and the job require. To do so, foster care needs to be described accurately in order that each recruited family knows, with reasonable specificity, what foster care is and is not, how the program functions, its strengths and it needs. The challenge is to present foster care in such a way that those families who can best meet the needs of the children in the Department's care are encouraged to come forward and participate in the program. At times a basic message needs to reach as many people as possible, and at other times a smaller group needs to be reached with more detailed and / or specific information. Mass media campaigns will be effective in increasing community awareness of foster care and the need for foster homes, while personal contact, including speaking engagements, informational meetings, and inquiry calls is more effective in helping people decide if foster care is right for them and for reaching target populations. The Rhode Island Foster Parent Association plays an important role in communicating the crucial role of foster parents and the special qualities they need to possess.

Community Involvement

Based on the concept that the responsibility for the welfare of a community's children and families ultimately rests with the community itself, the Department needs to establish on-going contact and partnerships with various public and private constituencies. Such constituencies could provide the Department with additional needed resources, expertise, and credibility in its efforts to recruit and retain quality foster homes, especially those in targeted and geographically specific areas. The Department presently does not have information available regarding the numbers of children who are placed outside of their city or region. Such information is necessary in order to direct recruitment campaigns at targeted communities.

Needs

Discussion in the subcommittee has focused on the following three alternative solutions for building the Department's targeted foster parent recruitment capacity.

- Expanding the Department's internal capacity by hiring one additional foster parent recruiter and one additional foster parent trainer; these staff would need to be bilingual / bicultural individuals with strong connections within the targeted minority communities.

- Utilizing a purchase of service model in which letters of interest would be solicited, resulting in a provider list of agencies interested in providing a package of services consisting of recruitment, home study, and pre-service training of prospective foster families. Agencies would receive a set fee for each family submitted to the Department who meet the criteria for licensing. In this manner, diverse target populations could be reached and the Department's licensing workers would not be further burdened.

- Entering into a contract with one agency for the recruitment, home study, and training services for a set number of families meeting certain characteristics.

General Recruitment

- Contract for the design of professional public relations / recruitment materials in the form of logo; press kits; posters; and newspaper ads; for general and targeted recruitment

- Contract for the production of a radio advertising campaign utilizing one general and one targeted commercial

- Contract for the production of a television advertising campaign utilizing a targeted and general commercial

- Contract for the development of a transit advertising campaign utilizing general and targeted ad copy

- Continue existing print advertising campaign, directed at both general and targeted populations

- Implement a foster parent bonus program as an incentive for foster parents referring prospective foster parents

- Continue / expand existing general and targeted recruitment activities – community events; informational meetings; targeted displays; work place recruitment

- Develop a foster parent recruitment campaign directed at state employees in partnership with state agencies and officials

Targeted Recruitment

Adolescents

- Survey existing foster parents to assess interest in this target population;

- Utilize existing foster parents of adolescents to identify / recruit additional resources

- Develop wraparound services to support adolescent placements;

- Enhance board rate for adolescents;

- Develop support services through RIFPA's Life Skills Program

- Provide specialized training, pre-service and in-service, for foster parents of adolescents

- Encourage relative and child specific foster parents of adolescents to continue service

- Develop targeted advertising described above

- Conduct targeted recruitment activities with staff at high schools, athletic programs; youth programs, churches

Minority Populations (African American, Latino, Southeast Asian)

- Meet with existing minority foster parents to enlist their support / recommendations for targeted recruitment efforts

- Promote the foster parent bonus program to encourage referrals

- Develop partnerships with community agencies / groups representing target populations to expand recruitment opportunities

- Collaborate with media serving target populations to run stories regarding foster parenting

- Develop partnerships with churches to promote foster parenting and assist in recruitment activities

- Develop partnerships with schools and parent groups to assist in recruitment activities and foster parent promotion

- Offer Spanish language foster parent pre-service training classes

- Expand work place recruitment activities to include businesses with large minority populations

Medically Fragile/Developmentally Disabled Children

- Direct targeted recruitment materials to support groups for parents of disabled children, service providers, and professional organizations

- Enlist the assistance of existing specialized foster parents in targeted recruitment efforts

Targeted Geographical Areas

- Forge partnerships with cities / towns with large number of children placed outside of their communities to identify additional foster home resources to keep children within the community or to bring them home.

- Conduct church focused recruitment activities with the goal of licensing one or two families per congregation as part of above

- Conduct school focused recruitment activities with the goal of licensing one or two families per school as part of above

- Conduct work place recruitment activities at businesses with local employees

Additional Recruitment Supports

- Emergency funds for relative foster parents to meet fire / space requirements

- Five year limit on drug conviction charges

- Executive director for RIFPA to focus upon for recruitment / retention activities

- RIFPA's Mentor Program to provide support services to foster parent applicants to increase retention through licensing

- Foster parent support groups through RIFPA

Foster parent retention is the first step in recruitment. It is essential to recognize that recruitment and retention are interrelated and that efforts to recruit qualified foster parents can only be as successful as the agency's ability to retain them. The 413 new generic foster homes licensed from 1/99 - 6/01, a 2 ½ year period, suggests that recruitment alone is not the issue and that the Department needs to significantly increase its efforts in the area of retention if it is to maintain and build upon its current supply of foster homes. It is incumbent upon the agency to work actively to retain foster parents by clearly communicating foster parents' rights and responsibilities, providing foster parents with opportunities to develop the knowledge and skills associated with success, and providing agency services to support foster parents in their roles.

FOSTER PARENT PRE-SERVICE TRAINING

Current:

Foster and adoptive parents play a crucial role in the lives of children and are essential links in the continuum of care that DCYF provides for the children in its care. Family Centered Practice and Concurrent Planning bring new focus and new challenges to our work, asking us to rethink our relationships with the families and children in our care, and also with the resource families - foster, kinship and adoptive - who are caring for the children. The roles of foster and adoptive parents, traditionally viewed as separate and distinct, can now be seen as

overlapping to a great extent. Approximately 70% of the adoptions in our state are foster parent adoptions, and many families who come in exclusively to adopt consider "legal risk" placements and also open adoptions.

Foster families and adoptive families are involved in the care and nurturing of children who have experienced significant loss and trauma, and may also be involved in working with biological parents. These families are some of our most valuable resources, and we, as an agency, have an obligation to nurture and support them. Training is a valuable method of providing this nurturing and support, and of supplying the resource families with the knowledge and "tools" that they will need in working with our children.

Pre-service training for foster and adoptive families, in response to recommendations of the Governor's Commission Report of June, 1999, has expanded and changed over the past two years. Up until 2001, the responsibility for all foster parent training fell on one Clinical Training Specialist. In 2000, the responsibility for foster parent training was moved from Staff Development (now the Child Welfare Institute) to the Adoption Preparation and Support Unit (now the Adoption and Foster Care Preparation and Support Unit). At that time, a second Clinical Training Specialist position was added for the purpose of foster parent training.

Responsibilities:

In the present calendar year, (2001), nine separate sessions of the pre-service core training have been held. The addition of a second foster parent trainer has also made it possible to offer training in two different locations within the state, Providence and North Kingstown. A total of 86 families (138 individuals) have been trained this year. Classes are nine weeks in length and include a range of subjects and a variety of training methods/tools.

The majority of the families that come through training are "new" (generic) foster parents. Some already have children in their homes or are visiting with particular children. These families are identified either as kinship caregivers (relatives) or as child specific placements

Needs:

Planning has been under way to offer dual training for foster and adoptive families. This effort was initiated in January, 2002. Dual training will, we believe, enhance the training experience for all of the families, and better prepare them for the issues they may need to face in the future - e.g., foster families will be better prepared to make the transition to adoption and lifelong commitment, while adoptive families will be better prepared to deal with issues of visitation (in the case of a "legal risk" placement) or work with birth families in open adoption situations.

Dual training will also greatly enhance our ability to provide training. At the present time we have four Clinical Training Specialists (CTS) who do adoption training and two CTS who train foster parents. If all six of the CTS are training joint groups of foster and adoptive families, we will be able to substantially increase the number of foster families trained each year. We will be able to offer training on a more frequent basis, cutting down on the amount of time that families must wait before getting into training.

Optimally, we hope to increase the number of Clinical Training Specialists by the addition of a dedicated trainer for training and retention of foster parents. This position would be dedicated to training minority families and would also be able to undertake bilingual training. This position would also be dedicated to ongoing in-service training such as "Fostering Discipline" and other specialized topics that deal with the issues our children present and meet the needs of our resource providers. Such efforts will hopefully improve the level of care and enhance the ability of the resource families to cope with problems and continue their commitment to the children.

Five years from now, dual training of foster and adoptive parents will be the norm, and by that time we may also be moving in the direction of dual licensure. The number of CTS in this unit would have been increased so that we could meet the needs of both pre-service and ongoing training for resource families. We would also have the staff to be able to better serve the specialized training needs of kinship caregivers, and the minority communities. We would be able to offer on-site baby sitting for resource families who are attending training as well as incentive bonuses for foster parents who attend special in-service training.

There are several other areas where improvement must happen if we are to better ensure "right placements and stability of placements". Worker training must be improved. Workers must be able to work in partnership with resource families, and they must learn the value of this - and how to do it! Post- adoption services must be increased so that placements do not fail while families sit on waiting lists at counseling agencies. Respite services and mentoring services must be expanded and made more available. Recruitment activities must be increased and improved so that placements may be made by actually choosing a home on the basis of suitability, rather than the fact that it is the only slot available.

FOSTER CARE LICENSING

Current:

Foster Care Licensing is a program within the Licensing Division that is executed by the Licensing Administrator.   This Division falls within the administration of Community Resources.   The Foster Care Program has one Senior Casework Supervisor and eight licensing Social Caseworkers. Two Data Control Clerks provide support for this program. Foster Care relies on it's own fire inspectors to evaluate safety and fire compliance of all foster homes. There are two Fire Inspectors.

Responsibilities:

Foster Care Licensing processes all generic, relative and child-specific applicants. The two points of entry for a referral include the Foster Parent Recruiter (generic) and the Family Service Units (kinship).

A completed application accompanies the applicant's BCI and Child Protective Services background checks. The Federal recommendation regarding criminal background checks is to automatically disqualify an applicant if a felony drug offense occurs within five years of the application. RI, however, had opted to disqualify any applicant with such a drug offense regardless of when this offense occurred.   The Department is currently involved in

discussions about amending its regulations to reflect the federal recommendation of the 5 year time frame on felony drug offenses. A number of applicants have had troubled pasts and have been able to successfully complete rehabilitation and turn their lives around.

An approved physician's reference is required on all applicants. A preliminary assessment of the home with the approval signature of a DCYF administrator is required on all kinship care applicants.

Once the referral is accepted, it is assigned to a licensing Social Caseworker for purposes of a home study, and to a fire inspector for a home safety evaluation. Additionally, applicants are instructed to contact a Foster Parent Trainer to register for the pre-service orientation course. All applicants are fingerprinted by local Police Departments. The NCIC results are returned to the Licensing Unit.

Upon successful completion of the licensing criteria, the applicant becomes licensed in the Foster Care Program. Their names and addresses are given to the Placement Unit and the Rhode Island Foster Parent Association. The Placement Unit reviews the records and begins to place foster children into these homes.

License renewals occur annually. The renewal process includes an updated BCI and Child Protective Services check with an updated home study evaluation. Approximately six hundred (600) new foster homes (and re-openings) are processed a year. There are one thousand, one hundred (1,100) licensed providers in the State of Rhode Island at the time of this report. This number includes relative, generic and private agency foster homes.

Needs:

The Senior Casework Supervisor screens and processes all of the incoming referrals and enters these applicants into the computer with the support of the data control clerks. He assigns the prospective provider to a social caseworker whose role is to facilitate the provider's process in complying with all licensing criteria. This Supervisor reviews and approves completed records of all new applicants, as well as examines each yearly renewal record. Together with the Licensing Administrator, he critiques questionable referrals and reviews all indicated child protection investigations against foster parents.

All closings are inspected and approved by the senior casework supervisor. All indicated and unfounded child protection investigations against foster parents are reviewed as well. The senior casework supervisor processes all requests for information regarding foster parents. Additionally, all foster care licensing Social Caseworkers are supervised by him.

Due to the high volume of licenses that are processed on a daily basis and the number of Social Caseworkers that must be supervised, the need for additional support for this supervisor remains a necessity. The optimum solution is to position a social casework supervisor, whose function it is to oversee all of the licensing Social Caseworkers, under the Senior Supervisor's management. Another possible solution is to position a Clinical Social Worker under the oversight of the Senior Supervisor. The Clinical's role would be to screen and process new referrals, review all child protection investigations against foster parents, and to process all requests for information and case closings.

There will need to be further discussion regarding the implementation of the 5 year limitation on drug felonies.

PLACEMENT UNIT

Current :

The Placement Unit currently consists of 1 Case Aid; 2 Social Caseworker IIs; and 1 Principal Resource Specialist; and one temporary secretary. The Principal Resource Specialist is serving in the capacity of unit supervisor, leaving 3 workers in the Unit. There is no bilingual capacity within the unit.

Responsibilities:

The Placement Unit is responsible for the daily coordination of requests for placements of children ages birth through eighteen in DCYF custody. Requests for placements include emergency, respite, planned, short, and long term placements. The Placement Unit staff maintain a daily listing of available "beds" including generic foster homes, shelters, and group homes. As requests for placements come in, the Unit staff attempt to match the children in need of placement with the most appropriate placement available. Efforts are made to place children within their region of residence whenever possible. Emergency shelter placements are routinely reviewed in order to move children along to more appropriate longer term placements. Placement Unit staff develop close working relationships with foster parents and agency staff.

On average, the Placement Unit places 110 **(unduplicated)** children every month; 72 of whom are entering placement for the first time (initial placements) and 38 of whom are subsequent placements. An average of 22 children are placed on any given day, but this number contains duplications over the course of a month, as children change placements or adolescents runaway and return. The available placement openings do not always match up with the demographics of the children needing placement. Certain groups of children are harder than others to find placements for: toddler and preschool boys; developmentally disabled and medically fragile children; and adolescents. Placements able to accommodate teen mothers and babies together and sibling groups are often difficult to find. Efforts are made to place children in culturally and linguistically similar homes whenever possible, but additional African American, Latino, and Southeast Asian foster placements are needed to facilitate this practice.

Needs:

Additional foster home resources, particularly for those "hard to place" groups, are necessary in order to meet the needs of children entering placement. Training for line staff is needed on gathering and communicating the types of child specific information that is critical for matching purposes. Training for line staff is also needed on how to deal with and treat foster parents. Numerous foster placements are disrupted and resources lost due to poor communication.

FOSTER CARE RETENTION

Over approximately a five year period, an alarming decline in the total number of licensed foster homes has been evident. A variety of factors including the increased adoption by foster parents, changes in licensing regulations and other specific reasons for closing have dramatically curtailed retention. Recent data indicate on an annual basis DCYF experienced a net gain of 25% in overall new recruitment vs. closure of existing homes.

A significant number of homes close due to licensing/regulatory action, Child Protective Investigations and various conflict with DCYF concerning case management issues. Many foster parents report problems during their involvement with DCYF and its' staff for a variety of reasons. The impact has had a resounding effect on recruitment efforts due to negative public relations.

The agency is perceived as bureaucratic, unwieldy, insensitive and lacking in a child centered staff who can respond to foster families need for service in a timely fashion. Personal styles of both administration and line staff have been described over a range from "caring to cruel".

Efforts over a three year period have made some positive impact on improving relationships between foster parents and DCYF. These improvements have reduced placement disruption and increased stability and consistency for children in foster care. Significant improvement is also noted between the Rhode Island Foster Parent Association and DCYF in establishing a partnership toward improving the foster care system and supporting and maintaining high quality foster homes.

Solutions:

❑ Provide increased formal training of new casework staff.

❑ Require a mandatory Casework Supervisor training for present supervisors around foster parent issues and concerns in an effort to improve relationships.

❑ Initiate ongoing in service training for all foster parents and re-establish fostering discipline module for homes who require this course.

❑ Increase utilization of Licensing Unit staff to improve relationships between DCYF staff and foster parents.

❑ Initiate a redevelopment of resources plan to encourage homes to continue in the program.

❑ Improve utilization and awareness of the RI FPA mentor program through introduction of new foster parents in pre-service training and new staff in the orientation process. Establish regular meetings with mentors.

❑ Increase awareness of the Foster Parent Liaison protocol through the Foster Parent Pre-service classes and staff orientation.

❑ Improve timely conflict resolution through Administrative Hearing process.

❑ Continue and enhance Communications Committee monthly meetings with foster parents to improve relationships.

❑ Establish regional chapters of the RIFPA to organize and improve retention and communication.

❑ Increase awareness of Family Centered Practice initiative.

❑ Initiate Foster Parent Retention Survey in conjunction with RIFPA to gather data and make necessary modifications to improve retention.

❑ Re-establish an Executive Director position for RIFPA to ensure coordination of programs and improve retention efforts.

RHODE ISLAND FOSTER PARENTS ASSOCIATION

The Rhode Island Foster Parent Association is located in Warwick, Rhode Island. It was formally incorporated in 1995 with funding received from the Department of Children, Youth and Families. A volunteer board of directors governs the Association.

The mission of the Association is to provide education and other forms of support to families that provide substitute care, and to the community-at-large, in order to further the cause of children who cannot live with their parents. The Rhode Island Foster Parents Association represents approximately 1100 foster families and 2000 foster children in the care of the Department of Children, Youth and Families. All of the programs and activities at the Rhode Island Foster Parents Association have been staffed by one full-time Mentor Program Coordinator and one full-time Life Skills Program Coordinator; one part-time Office Manager, and one part-time Teacher Assistant for Life Skills.

The Rhode Island Foster Parents Association's primary function is to provide support services to foster families through the Mentor Program; provide training and develop independence for teens who are being fazed out of the foster care system through the Life Skills Program; and finally offering limited financial assistance to teens 14 to 21 through our Teen Grant Program who are in foster care whether in foster homes or residential programs. Other programs the RIFPA is responsible for are the monthly Newsletter, Holiday Gift Distribution Program, Web Site, The Annual Town Meeting, and The Foster Parent Appreciation Dinner. The Cribs, Beds, Clothes Oh My Program is exclusively organized and facilitated by the Association through donations.

Mentor Program

The Mentor Program provides twenty-four (24) hour support through the Help Line for all licensed foster parents. In addition, during their first six (6) months of fostering, a newly approved foster parent is matched with a veteran foster parent who is available to provide personal, one on one assistance and share their experiences. It is the strong belief of the Mentor Program that they will be successful in retaining foster parents by offering crucial support during the initial six months when new foster parents are asking questions like "is this child's behavior normal?", "am I capable of providing for the needs of this child?", or "how is

this child going to affect the other children in my home?" The Mentor Program is a service dedicated to new foster parents who may need encouragement and direction in order to fulfill the needs of the foster children in their care. The Mentor Program serves as an avenue for retention. Sharing positive experiences of new foster parents and their Mentor, it also serves as a recruitment resource by foster parents making referrals. The Mentor Program's primary function is providing support services. On average, the Help Line receives 170 calls per month. Seventy newly licensed foster parents are serviced monthly as well as countless other foster families who still call on their former mentors for advice and direction. The Mentor Program and the Help Line are advertised in the monthly RIFPA Newsletter.

Teen Grant Program

The Teen Grant Program was designed to provide funds for activities that would enhance the preparation for independence for youth in DCYF care. It is available for activities that contribute to personal growth, skills building, educational pursuits, sports, and other areas that enhance self-esteem. This program is now available to teens ages 14 through 21, which constitutes a lowering of the age qualification from the previous age of 16. This will encompass a larger number of teens able to access moneys for positive promotions.

Newsletter Program

The RIFPA Newsletter is a monthly publication that provides information regarding the Association and DCYF activities. The Newsletter is distributed to all licensed foster homes as well as DCYF and other agencies upon request. This publication has a mailing list of approximately 1300 foster homes and businesses. The Newsletter is the main source of information received by foster families regarding any news or upcoming events or training. This is a major source of recruitment as well as retention.

Web Site

The web site is a new resource of information that the RIFPA has embarked upon within the last two years. It also provides foster families as well as other interested individuals information regarding the Association and the programs they service. It allows for potential recruitment of foster parents and is a support and informational guide to present foster families and outside organizations.

Life Skills Program

The Life Skills Program provides detailed instructions to DCYF involved teens that reside in out-of-home placements, ages 16 to 21 regarding survival and independence. One full-time coordinator and one part-time teacher assistant as well as two teacher aides staff this program. Life Skills provides transportation to all regions of Rhode Island to teens that are participating in the program. Nightly, nutritious meals are prepared with the teens as well as reinforcing positive cleaning skills. Sixteen weeks of independent living skills ranging from food management, housing, money management, emergency and safety skills, job seeking, and maintaining skills. In addition, there is a $200.00 incentive check upon completion of the program, which is distributed at a graduation ceremony. The graduation features the teens with their invited guests, DCYF staff, and a guest speaker. There are multiple field trips that

offer information pertinent to the students regarding their future. There are also reunions for graduates inviting them to participate in fun activities, share stories over pizza and soda, or get involved in civic organization promoting the need for quality foster homes. These are just a few of the opportunities offered to our graduates of Life Skills.

One-Day Town Meeting

The RIFPA in conjunction with the DCYF implement all facets related to the production of a One-Day Town Meeting between the RIFPA and DCYF including representation from the Child Welfare League of America. This meeting consists of foster parents, DCYF personnel, and an outside facilitator to review, assess, and recognize achievements as well as identify new goals for improving relations between the RIFPA and DCYF. It was designed to identify the weak areas that need to be acknowledged with a definitive plan on how to achieve an amicable solution.

The Appreciation Dinner

The RIFPA is responsible for implementing all necessary activities for the presentation of a foster parent recognition dinner. This would consist of where and when the dinner would take place, invitations to foster families as well as DCYF staff, and state dignitaries. Also, the RIFPA is responsible for securing a guest speaker, recognition awards, entertainment, programs, door prizes, flowers, and other necessary material related to this activity. Any written material must acknowledge the DCYF as the sponsoring agency. Everything related to this activity must have prior approval of the DCYF.

Plans For Expansion for the Rhode Island Foster Parents Association

1. A foster parent survey will be implemented researching information to assist in ways of retaining present foster homes and looking for suggestions from foster parents regarding recruitment of new foster families.

2. Bonus Program is being initiated by the RIFPA to provide an incentive for foster parents to recruit new foster parents by being reimbursed for their referrals. Another form of a bonus program is to have foster parent recruitment parties. These parties will be hosted by a foster parent who will be paid a stipend for hosting the party and be allocated funding for refreshments.

3. The RIFPA would like to sponsor the final foster parent training class at the RIFPA facility to expose prospective foster parents to the various programs and services provided by the RIFPA. It would also serve as an introduction to the Association, which would encourage higher participation in Association related activities. This would allow foster parents the knowledge of the Mentor Program and Life Skills Program, which would serve as a retention mechanism for continued support with their foster children. Knowing that there is that support would encourage foster parents to recruit new foster parents because of the positive experience as well as the support and services provided.

4.   Life Skills Open House would be the initial introduction for foster parents, teens, Life Skills staff, and Board Members of the Association to the RIFPA facility. Meeting the staff at the Association and becoming aware of the programs and services available to foster families, foster parents may increase the retention of teens in their homes. Recognizing that many teens find their own foster homes that become licensed, they are a prime resource for recruitment of foster homes. As they are fazed out of the home due to age or higher education, the home may be utilized for another teen rather than closed.

5.   Presently the RIFPA is implementing an Enrichment Program, which will provide funding for youth under the age of 14 to pursue an activity that they feel would enhance their confidence and creativity. With this funding available, it would assist the foster parents in contributing less of their own funding in order that the foster child be able to pursue a dream. With less out-of pocket expense, we should be able to recruit and retain more foster families.

6.   A Mentor Social would be implemented to allow mentors and mentorees the opportunity to meet quarterly in addition to phoning on a regular basis. This social gathering would form a stronger bond and trust between mentor and mentoree. It would also serve as a future opportunity for a new foster parent to feel confident enough through her own experience to recommend fostering to others.

7.   On-site training would provide a central locale within the state to offer training that would be helpful in raising foster children. It would also be collaboration with DCYF and strengthen the relationship between the two organizations that are *both* working for the foster children in hopes of recruiting and retaining good foster parents.

8.   Develop a Resource Center of information through books, videos, and any other forms of material that may be helpful to a foster child or foster parent. The resource center would assist foster parents in gaining knowledge about a particular issue that is plaguing the home. Accessing the information may help in retaining the home. The resource center would be located at the RIFPA office.

9.   Develop recruitment opportunities for foster parents of adolescents in conjunction with the Life Skills Program. Initiate a support group for teens in foster care ages 13 and up that may be matched with an appropriate Life Skills Graduate to be utilized as Youth Mentors. Work with the Life Skills Coordinator to develop support groups, services, and trainings for foster parents of adolescents and encourage foster parent participation in a parent advisory board or committee.

10.   Increase staff to include a full-time Executive Director. With the leadership of the Executive Director in place all of the above goals attainable. With additional funding as well as grant writing, additional ideals can become a reality.

11.   The Mentor Coordinator will hire two new mentors who will be minorities.

12.   Regional Chapters will be organized and meetings to be held on a regular basis. These meetings will be advertised in the monthly Newsletter with dates, times, and

places. Representatives will report back to the Board with ideas, concerns, and possible solutions. These Regional Chapters could serve as recruitment for prospective foster parents and be helpful in maintaining present foster parents through support.

Resources Needed

In order to achieve the goals for the Association, additional funding in the way of an Executive Director is required. The Executive Director would possess the ability to control, guide, and direct the Association in a professional manner that would enable the organization to be stable, provide a solid foundation for the growth it needs, and prosper with the leadership skills necessary to accomplish its goals with positive results. In order to attain success in recruitment and retention from the Association, the Executive Director will work collaboratively with the DCYF recruiter in regards to a media campaign elaborating on the services and programs of the Association. He/she will work with the Life Skills Coordinator to enhance the recruitment and retention of foster families of teens through their own initiative.   Working with the Mentor Coordinator, the Executive Director will advocate for additional support services for new foster families as well as veteran foster families who are experiencing difficulties and are at risk. These additional services may include resources such as literature, videos, or trainings which the Association would like to host with guest speakers.

In conclusion, it is essential that funding for the Executive Director's position be approved. For positive results in recruitment and retention, the Association requires the leadership and direction of an Executive Director. Recruitment and retention of foster parents will either be the problem or the solution if an Executive Director is not in the equation. If any of the pieces of the puzzle are missing, the picture will never be complete.

*S*UMMARY OF *R*ECOMMENDATIONS

Each of the units/divisions within DCYF who have involvement with Foster Care have delineated the committee's recommendations below. There are also recommendations from the Foster Parent Association and community providers. There has been no consensus reached as to the integration of staff who recruit, train, license and support foster families. It is the recommendation of the committee that DCYF continue to look at the physical placement and administrative reporting of the various units so that continuity of services will be provided both to children and Foster Parents.

The financial effects of the committee's recommendations are delineated in the appendix. Further consideration of the appropriate expense and sustainability will be ongoing in the implementation of the report's recommendations.

Recruitment

Discussion in the subcommittee has focused on the following possibilities for building the Department's foster parent recruitment capacity.

❑ **Utilize a purchase of service model in which letters of interest would be solicited, resulting in a provider list of agencies interested in providing a package of services consisting of recruitment, home study, and pre-service training of prospective foster families.**

❑ **Expand the Department's internal capacity for targeted recruitment by hiring one additional foster parent recruiter; this staff member would optimally be a bilingual / bicultural individual with strong connections within the targeted minority communities. This position would also be responsible for other areas of targeted recruitment including adolescents.**

❑ **Expand work place recruitment activities to include businesses with large minority populations.**

❑ **Expand current media advertising, initiate new media campaign.**

❑ **Emergency funds for relative foster parents to meet fire / space requirements**

Training

Dual training for foster and adoptive families has been implemented as of January, 2002. Dual training will greatly enhance our ability to provide training. At the present time we have four Clinical Training Specialists (CTS) who do adoption recruitment and training and two CTS who train foster parents. The supervisory position is currently vacant. If all six of the CTS are training joint groups of foster and adoptive families, we will be able to substantially increase the number of foster families trained each year. We will be able to offer training on a more frequent basis, cutting down on the amount of time that families must wait before getting into training.

Optimally, we hope to increase the number of Clinical Training Specialists by the addition of a dedicated trainer for training and retention of foster parents. This position would be dedicated to training minority families and would also be able to undertake bilingual training. This position would also be dedicated to ongoing in-service training such as "Fostering Discipline" and other specialized topics that deal with the issues our children present and meet the needs of our resource providers. Such efforts will hopefully improve the level of care and enhance the ability of the resource families to cope with problems and continue their commitment to the children.

❑ **The existing vacancy of Chief Casework Supervisor for Adoption and Foster Care Preparation and Support must be filled. This position is vital to the program's continued growth.**

❑ **An additional Foster Parent Trainer is recommended. This staff member would optimally be a bilingual / bicultural individual with strong connections within the targeted minority communities.**

❑ **On-site day care for resource families who are attending training.**

❑ **Incentive bonuses for foster parents who attend special in-service training.**

❑ **Worker training must be improved.**

❑ **Workers must be able to work in partnership with resource families.**

Licensing

The Senior Casework Supervisor screens and processes all of the incoming referrals and enters these applicants into the computer with the support of the data control clerks. He assigns the prospective provider to a social caseworker whose role is to facilitate the provider's process in complying with all licensing criteria. This Supervisor reviews and approves completed records of all new applicants, as well as examines each yearly renewal record. Together with the Licensing Administrator, he critiques questionable referrals and reviews all indicated child protection investigations against foster parents.

All closings are inspected and approved by the senior casework supervisor. All indicated and unfounded child protection investigations against foster parents are reviewed as well. The senior casework supervisor processes all requests for information regarding foster parents. Additionally, all foster care licensing Social Caseworkers are supervised by him.

❑ **Due to the high volume of licenses that are processed on a daily basis and the number of Social Caseworkers that must be supervised, the need for additional support for this supervisor remains a necessity. The optimum solution is to position a social casework supervisor, whose function it is to oversee all of the licensing Social Caseworkers, under the Senior Supervisor's management.**

❏ **The Federal recommendation is to automatically disqualify an applicant if a felony drug offense occurs within five years of the application. RI, however, had opted to disqualify any applicant with such a drug offense regardless of when this offense occurred. The Department is currently involved in discussions about amending its regulations to reflect the federal recommendation of the 5 year time frame on felony drug offenses.**

Placement

❏ **Additional foster home resources, particularly for those "hard to place" groups, are necessary in order to meet the needs of children entering placement.**

❏ **Placements need to be made by actually choosing a home on the basis of suitability, rather than the fact that it is the only slot available. Training for line staff is needed on gathering and communicating the types of child specific information that is critical for matching purposes. Training for line staff is also needed on how to deal with and treat foster parents. Numerous foster placements are disrupted and resources lost due to poor communication.**

Retention:

Foster parent retention is the first step in recruitment. It is essential to recognize that recruitment and retention are interrelated and that efforts to recruit qualified foster parents can only be as successful as the agency's ability to retain them. The 413 new generic foster homes licensed from 1/99 - 6/01, a 2 ½ year period, suggests that recruitment alone is not the issue and that the Department needs to significantly increase its efforts in the area of retention if it is to maintain and build upon its current supply of foster homes. It is incumbent upon the agency to work actively to retain foster parents by clearly communicating foster parents' rights and responsibilities, providing foster parents with opportunities to develop the knowledge and skills associated with success, and providing agency services to support foster parents in their roles.

Some proposed solutions:

❏ **Provide increased formal training of new casework staff.**

❏ **Require a mandatory Casework Supervisor training for present supervisors around foster parent issues and concerns in an effort to improve relationships.**

❏ **Initiate ongoing in service training for all foster parents and re-establish fostering discipline module for homes who require this course.**

❏ **Improve utilization and awareness of the RI FPA mentor program through introduction of new foster parents in pre-service training and new staff in the orientation process. Establish regular meetings with mentors.**

❑ **Increase awareness of the Foster Parent Liaison protocol through the Foster Parent Pre-service classes and staff orientation.**

❑ **Improve timely conflict resolution through Administration Hearing process.**

❑ **Continue and enhance Communications Committee monthly meetings with foster parents to improve relationships.**

❑ **Establish regional chapters of the RIFPA to organize and improve retention and communication.**

❑ **Increase awareness of Family Centered Practice initiative.**

❑ **Initiate Foster Parent Retention Survey in conjunction with RIFPA to gather data and make necessary modifications to improve retention.**

❑ **Respite services must be expanded and made more available.**

❑ **A rapid response system. This system would be set up to respond to the needs of biological, adoptive, and foster families who are experiencing   a non abuse/neglect related crisis during hours when an assigned worker is not generally available.**

RIFPA

In order to achieve the goals for the Association, additional funding in the way of an Executive Director is required. The Executive Director would possess the ability to control, guide, and direct the Association in a professional manner that would enable the organization to be stable, provide a solid foundation for the growth it needs, and prosper with the leadership skills necessary to accomplish its goals with positive results. In order to attain success in recruitment and retention from the Association, the Executive Director will work collaboratively with the DCYF recruiter in regards to a media campaign elaborating on the services and programs of the Association. He/she will work with the Life Skills Coordinator to enhance the recruitment and retention of foster families of teens through their own initiative.

❑ **Working with the Mentor Coordinator, the Executive Director will advocate for additional support services for new foster families as well as veteran foster families who are experiencing difficulties and are at risk. These additional services may include resources such as literature, videos, or training which the Association would like to host with guest speakers.**

Community Providers

Community agency personnel participated in the subcommittee and contributed to the discussions and recommendations as well. It was noted in several discussions that community agencies were better able to provide the wrap around services to families that were necessary in many situations. Families, whether they are biological, foster or adoptive, need to know who and where to turn when they are in need of information or services. An ideal system of care will not only be able to

direct a family, but have sufficient available services to assist families in providing for their child's needs

APPENDIX M: REPORT OF THE CURRENT REALITY COMMITTEE OF THE RHODE ISLAND SYSTEM OF CARE TASK FORCE (SEPTEMBER 2001)

RHODE ISLAND SYSTEM OF CARE TASK FORCE

REPORT OF THE CURRENT REALITY

SUBCOMMITTEE

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Introduction

The Current Reality Subcommittee of DCYF System of Care Task Force was charged with the duty of examining the quality of care available to DCYF-involved children. The subcommittee met at the Office of the Child Advocate on 10 occasions between April and August of 2001. At the outset, the subcommittee identified topics and issues on which to focus its attention. Once an agenda was created, representatives from major state departments were invited to subcommittee meetings to provide information and insight regarding their respective areas of expertise and/or topics of interest. Throughout these meetings, the subcommittee analyzed data, statistics and other relevant information for each agenda topic. The subcommittee adopted specific recommendations at the conclusion of each meeting. Recommendations are summarized in this report for submission to the System of Care Task Force.

It is important to note that the subcommittee acknowledged the need for all professionals working within the system to invariably give due consideration to a number of key factors when developing an overall plan for the ideal system of care. These factors are incorporated by reference within all recommendations made in this report. They are:

> ➢ focus on a family-centered system

> ➢ enhancement of early intervention and prevention efforts

> ➢ cultural sensitivity and diversity awareness

> ➢ the importance of school and community ownership of children

> ➢ system-wide integration, communication and coordination

Respectfully submitted:

Laureen D'Ambra, Esquire
Child Advocate
Current Reality Subcommittee Chairwoman
September 15, 2001

Contracted Programs

Tom Bohan and Carol Spizzirri, representing DCYF, provided expert assistance and information to the subcommittee. The RIPEC report was also consulted, with some data taken directly from the report.

I. Current Reality

A. At the end of calendar year 1999, DCYF reported a caseload of 8,064 children. 42.1% of these children living with parents or relatives, not including kinship foster care; 23.6% living in subsidized adoption; 8.2% living in non-relative foster care; 7.4% living in residential facilities and group homes, of which 134 were living in out-of-state facilities; 6.6% living in kinship care; 2.3% lived at the Training School; 1.6% lived independently or in supervised apartments; 1.4% were "runaways"; 1.4% lived in emergency shelters;1.3% lived in private agency foster care homes; and 0.7% lived in psychiatric hospitals. The remaining 3.4% lived with friends or guardians, lived independently without funding or supervision, lived in non-psychiatric hospitals, pre-adoptive homes, unsubsidized adoptions, prison or substance abuse facilities.

B. In 2000, DCYF reported that 35.1% of children spent one year or less in out-of-home care, 20.5% spent one to 2 years in out-of-home care, and 27.1% spent more than 3 years in out-of-home care. About one in eight children (12.1%) of children in DCYF's caseload at the end of December 1999 had been in care for six years or longer.   Males comprised approximately 58.5% of the caseload; 41.5% were female. At this same time period, the race and ethnicity of the caseload was as follows: 57.3% white; 19.7% black, 13.6% Hispanic; 1.9% Asian/pacific Islander; 1.4% Native American; 6.1% other or unknown. Over 50% of the population of children were 12 years of age or older; 30% were children between the ages of 6 and 11; and 20.1% were children under age 6. Almost one-half of the children in care lived in Central Falls, Pawtucket, Providence and Woonsocket.

C. In FY 2001, Federal funds supported 38.6% of DCYF's expenditures; State general revenues accounted for 60.6%.   Treatment and support services -- juvenile corrections, psychiatric hospitalization, residential treatment, board and care -- consumed over 62 cents of every dollar provided to DCYF in FY 2001.

D. DCYF contracts with 73 residential treatment programs operated by 26 separate entities. The total number of contracted placements are 810: 114 slots are for children ages 12 and under; 544 are for children ages 13-20; and 152 slots are for specialized foster care for children ages 1-17. Of the total 810, 176 slots are for females, 377 for males, and 257 are coed. (89 additional contracted placement beds will be added by June, 2001, pursuant to the 8/27/01 Second Amended Consent Decree. At least 33 placement beds are dedicated to female adolescents.)

E. Pursuant to a Federal District Court civil action, in August, 2001, DCYF admitted to violating the First Amended Consent Decree of 1989 in that it placed 294 youths in 1310 episodes of night-to-night placement from January 1, 2001 to June

30, 2001. DCYF stated that it will no longer place children committed to it care in night-to-night placement for any number of nights, absent unusual placement emergencies. DCYF will also prepare written policy and protocols requiring administrative approval prior to placing any child night-to-night, and that any child so placed will attend school. DCYF has also agreed, among other things, to increase the number of residential placements for female youth and male youth.

F. The 2001 Rhode Island General Assembly approved in Budget Article 13 increases in the amount of $3.69 per day for foster care and 3.8% for contracted DCYF service providers.

II. Solutions

A. "Prevention" needs to be defined and clarified, and then incorporated into policy and practice for each area of DCYF service delivery and within the system of care network. The State needs to provide more resources and a stronger commitment to primary and secondary prevention programs.

B. Foster care and service provider rates should be increased.

C. Night-to-night should be eliminated by expanding placement options, particularly for adolescent girls. (Second Amended Consent Decree dated 8/27/01 addresses this issue.)

D. DCYF should devote more personnel and resources to yield a concerted, creative effort, including extensive community outreach, to encourage families to come forward to provide foster care and specialized foster care.

E. DCYF should assure an adequate placement continuum of care to accommodate the special and particular needs of children within its care.

F. DCYF Family Service Unit caseworkers should work a more flexible, rotating schedule to be available when their clients most need them: evenings and weekends.

G. DCYF, CASA and the Family Court should closely examine the system of care with respect to the amount of time children spend within the system and without a permanent home. DCYF statistics reveal that nearly 3 in 10 children spend more than 3 years in care and nearly 1 in 8 spend 6 or more years in care. This data contradicts the mandate that "foster care" should only be used as a temporary solution to perilous problems within families. Federal and State law prescribe shorter time periods in which to achieve permanency for children.

H. In-home services available to adolescents need to be more available and expanded statewide to prevent the out-of-home placement. Crisis intervention teams must be readily accessible to meet the needs of youth and their families.

I. Family-Centered Practice and Care Management Teams proposed in DCYF pilot programs should be supported.

J. DCYF professionals should comply with the law mandating at least 20 hours of training per year.

K. To address the problem of night-to-night, DCYF should closely examine the development of a rapid diagnosis/assessment center and/or capacity for adolescents upon their first entry into State care to determine appropriate service plans, including but not limited to crisis intervention and wrap-around services to facilitate family reunification and/or identification of the placement needs of said youth. (Paragraph 11 of Second Amended Consent Decree dated 8/27/01.)

Out-of-State and In-State Purchase-of-Service Placements

Tom Bohan, Carol Spizzirri, representing DCYF, and Betsy Ison and Gail Dalquist, representing Placement Solutions, provided expert assistance and information to the subcommittee.

I. Current Reality

A. As of April 30, 2001, the status regarding POS slots was as follows: 341 children were placed by DCYF in purchase-of-service (POS) beds in approximately 37 residential treatment programs (33 of which were out-of-state programs) and 3 therapeutic foster care programs in Rhode Island. A total of 110 children were placed in one of 4 Rhode Island residential treatment facilities in POS beds at an average per-diem rate of $199.95 per child. A total of 187 children were placed in one of 33 out-of-state residential treatment facilities in POS beds at an average per-diem rate of $258.20 per child. A total of 49 children were placed in one of 3 in-state therapeutic foster care programs at an average per-diem rate of $135.16 per child. On average, these children have been opened to DCYF's Family Service Unit for about 3.25 years. As of June 26, 2001 when there were 349 children in POS beds, 109 were female and 240 were male. A high percentage of DCYF's budget is spent on out-of-state POS placements for a relatively small number of emotionally disturbed children and sexual offenders.

B. DCYF has developed a Care Network under the framework of the family-centered, community-based model, as one method of attempting to return out-of-state children to the State's system of care. Approximately 50 slots have been allocated thus far. There is an RFP for a second "network" to serve 20 children.

II. Solutions

A. If the State were to provide additional in-state placement options for children requiring a high level of care in a residential setting, reliance on out-of-state residential care could be reduced. For example, at least 44 out-of-state purchase-of-service slots are occupied by adolescent male sex offenders because the State lacks treatment options for them in-state.

B. The State should develop a comprehensive plan for returning children placed out-of-state to the State's system of care. The plan should focus on consistency of

treatment and permanency goals, as well as, sufficient planning time for clinical case management coordination throughout the transition process.

C. The State should eliminate unnecessary psychiatric hospital days by adding step-down beds.

D. DCYF should carefully evaluate the operation of the Care Network to date in order to correct problems and make other necessary changes before children become involved with the second Network.

E. DCYF should expand its efforts to target, recruit and identify foster families for adolescents. (Specific requirements are detailed in the Second Amended Consent Decree entered 8/27/01.)

Psychiatric Hospitalization

Dr. Gregory Fritz of Bradley Hospital, and Dr. Charles Staunton of Butler Hospital provided expert assistance and information to the subcommittee.

I. Current Reality

A. The number of children and youth in psychiatric hospitals has continued to increase: Bradley is predicting 950 admissions this year compared to 894 admission the previous year; Butler is experiencing a similar upward trend from the 679 admissions received in 2000. Between January and July of 2001, 122 children have been on a waiting list (ranging from a few hours to 5 days) for psychiatric beds. To a large extent, increased demand is related to fewer treatment opportunities in less restrictive settings. The most common diagnoses given to hospitalized children are: Adjustment Disorder (largely mixed disturbance of mood and conduct); Major Depression, recurrent; Major Depression, single episode; and Post- Traumatic Stress Disorder; Bipolar Disorder.

B. The State has a significant shortage of child psychiatrists. In addition, most do not practice forensic child psychiatry. The majority require fee-for-service payment as insurance reimbursement is reportedly low and the paperwork "onerous."

C. The State lacks sufficient out-patient services for children and families. This has been attributed to a minimal supply, despite the demand, reflecting inadequate reimbursement rates. Family members wait much too long for necessary services.

D. The State lacks (1) sufficient residential step-down alternatives to psychiatric hospitalization and (2) appropriate aftercare services. These deficiencies have caused some children to be readmitted to the hospital. These problems most affect the adolescent patient population. A significant number of these youth have substance abuse problems and/or pending wayward petitions.

E. Family therapy must meet the specialized needs of the family and be readily available.

    F.   Both Medicaid and insurance reimbursement rates are too low.

    G.   Psychiatric care for children and youth in Rhode Island, whether in-patient or out-patient, has been primarily driven by our system of reimbursement for care, rather the individual needs and best interest of the patient.

II.   Solutions

    A.   The State needs to develop alternatives to psychiatric hospitalization that include specialized residential program acute-care beds, therapeutic foster care, CIS out-patient services, and family therapy.

    B.   The State needs to closely examine reimbursement rates and payment methods for child psychiatrists.

    C.   The State Department of Business Regulations should review whether insurance companies are shouldering their share of the payment burden for psychiatric hospital costs and out-patient services.

    D.   All mental health out-patient services need to be improved. Insurance companies need to endorse family therapy. Family therapy is a highly effective and powerful medium which demands highly qualified practitioners. Family therapy could be more readily available via financial incentive policies and realistic reimbursement rates adopted by insurance companies.

    E.   To help shorten the total length of time children remain hospitalized, a comprehensive, multidisciplinary review of their discharge plan and likely date of discharge should occur upon admission.

    F.   EPSDT should be utilized as a potential alternative to psychiatric hospitalization, or upon discharge, as a way to transition youth from the hospital to gradual step-down service plans.

Outpatient Psychiatric, Mental Health and Substance Abuse Services

Elizabeth Earls, Executive Director of the Rhode Island Council of Community Mental Health Organizations, Inc., and Dave Lauderbach, Executive Director of Kent County Mental Health Center, Inc., provided expert assistance and information to the subcommittee.

I.   Current Reality

    A.   Troubled and emotionally disturbed girls and boys of all ages, races and ethnic backgrounds, and socio-economic status, make-up the population of children requiring a comprehensive and easily accessed system of outpatient mental health and substance abuse treatment. Most of these children live with their birth or adoptive families; however, many must temporarily live in substitute foster care, group homes, residential facilities, correctional facilities and hospitals. Some have access to private insurance coverage, others receive Medicaid or are uninsured. The population of children requiring mental health services on a short- or long-

term basis may come to the attention of DCYF and the Family Court in a variety of ways, including via voluntary placement agreements, or petitions alleging dependency, neglect, abuse, waywardness or delinquency.

Service providers throughout the State consistently agree that demand for treatment far outstrips supply, and that the treatment provided does not always meet the particular needs of children and their families. Furthermore, preventive treatment, which is provided in a variety of venues, is insufficient and uncoordinated. When communities and school systems identify troubled children, some do not make reasonable efforts to assist and treat them within the community, rather they turn to DCYF and the Family Court to assume responsibility for their children. Furthermore, a clear "big picture" view of State-wide publicly and privately available services and how they are accessed is not currently available to all those working within the child welfare system. Consequently, gaps in knowledge and confusion hinder the delivery of appropriate services in a timely fashion.

B. The Rhode Island Council of Community Mental Health Organizations, Inc., is the primary provider of DCYF-funded mental health services for DCYF-involved children and their families. Council members are: Community Counseling Center, Inc.; East Bay Mental Health Center, Inc.; Kent County Mental Health Center, Inc.; Mental Health Services of Cranston, Johnston, and Northwestern Rhode Island, Inc.; Newport County Community Mental Health Center, Inc.; NRI Community Services; The Providence Center; Riverwood Mental Health Services, Inc.; and South Shore Mental Health Services, Inc.

C. A number of Children's Intensive Services (CIS) programs exist in the State to provide preventive treatment for emotionally disturbed children qualifying for Medicaid or without insurance. The goal of CIS programs is to maintain children of all ages in their homes by providing an intensive level of services for children at risk for psychiatric hospitalization or in acute crisis. Services are delivered on a 24/7 schedule, usually consisting of 2 to 2.5 hours per week for a 6-month period. Approximately 10% of clients are serviced beyond the 6-month period. Services include therapy, consultation, case management, medical management, outreach, parent education. CIS services both home-based and out-patient, do not include sufficient targeted training groups for parents and peer counseling for children and youth. CIS does not provide respite care. There is a waitlist for CIS programs State-wide.

D. The State lacks an adequate supply of home-based services post-CIS; i.e., a step-down program to deliver less intensive in-home services -- 1 to 2 hours per week for variable time periods. Consequently, about 35% of clients require re-enrollment in a CIS program after having been discharged from CIS. Some chronically, mentally ill children may need services indefinitely.

E. The State contracts with various programs to provide youth diversionary, outreach and tracking, early intervention, comprehensive emergency, and family preservation services on an outpatient basis. Mental health and/or substance abuse treatment is a component within many of these programs.

F. Various State departments operate programs aimed at helping children with mental health and substance abuse problems. For example, MHRH provides an adolescent substance abuse program, and DHS administers CEDARR, EPSDT, and Rite Care.

G. The State lacks sufficient mental health and substance abuse treatment providers who can deliver direct services to bilingual clients, while also focusing on incorporating an awareness of cultural issues and differences into individual treatment plans.

H. The State lacks a sufficient supply and continuum of mental health treatment options for children and their families post-adoption.

I. The State has a significant shortage of child psychiatrists. In addition, most do not practice forensic child psychiatry. The majority require fee-for-service, vastly diminishing their accessibility to most families.

J. Pursuant to a contract with DCYF, beginning in January, 2001, Placement Solutions started to review out-of-state and purchase-of-service placements for the purpose of providing recommendations and oversight for the transition of children from out-of-state care to in-state care solely from a clinical perspective. Focus to date has been on establishing standards for "level of care" criteria, with attention to time frames and specific services necessary for a successful family-centered transition.

II.   Solutions

A. The mental health and substance abuse treatment system can be better coordinated throughout the State. Computer technology should be used to organize, streamline and process data, and to manage an information system that is current and easily accessed. A program of public education should be developed and implemented to help fill gaps in knowledge and information among professionals and others regarding the needs of and services for emotionally disturbed children and substance-abusing youth.   This educational program should also include information about funding and payment options and procedures, as well as, the impact of the mental health parity law.

B. Individual communities and schools must truly own their children. This must be committed to both the early identification of family-related problems and the timely provision of specifically tailored community-based services to prevent disruption of the family and the physical and psychological exit of children from the community and school.

C. CIS and less intensive programs, outreach and tracking, and other outpatient mental health and substance abuse treatment options should be available to all children who need this service.

D. Cultural sensitivity and the communication needs of non-English-speaking families should be addressed within the context of continuing education training

programs and workshops for public and private employees servicing diverse populations within the State. In addition, special circumstances, including sibling-related issues within the system of care, sexual orientation of children or their parents, kinship care, adoption, AIDS, should be appropriately addressed within the context of initial and continuing training, and staff supervision. Toward that end, the Child Welfare Institute should ensure a diverse staff capable of assisting DCYF and community-based providers to address cross-cultural views of family roles, discipline, and other parenting issues. (Recommendations in *The Governor's Commission to Study Children in Foster Care and Adoption Report* concerning cultural sensitivity should continue to be implemented.)

E. Crisis intervention services must be available on demand. Out-patient psychiatric, individual counseling services and diagnostic assessment must be readily available, accessible and affordable to meet the needs of individuals and families. Waiting lists must be eliminated.

CASSP and Wrap-around Services

I.   Current Reality

A. CASSP is a family-centered service system to assist families at risk. It adopts a holistic approach toward treating the family, one that stresses the importance of accurate assessment of symptoms to identify the most effective path toward problem resolution. As a family-centered model, it is designed to create one comprehensive resource system and to fill in gaps that a more fragmented service plan might expose. A vital component of CASSP is the importance placed on wrap-around services.   Wrap-around refers to a service approach that focuses on identifying what children and families need, building on their strengths and creating treatment plans that are individualized, comprehensive and flexible. Wrap-around requires that service providers, especially those responsible for case management, recognize that one problem within the family and among family members is usually affected by others; thus services in their totality must address multiple issues.   Effective wrap-around services are based in the community closest to the child's home, and incorporate open and frequent communication among service providers (as well as with clients) so that they work in concert with one another. Roles are clearly defined and tasks are well-coordinated. Progress toward achieving goals is closely monitored and necessary changes in the plan are made to reflect the ongoing evaluation of each family member's progress. Rhode Island's CASSP system is effective; however, implementation of the wrap-around model is hindered by a lack of sufficient resources and financial commitment. DCYF has recently hired two coordinators to implement a family-centered system of care model that will hopefully expand and facilitate the type of planning currently done by CASSP.

II.   Solution

A. The CASSP system of care should be a model for expansion within the State. More than lip service must be paid to the notion that an effective system of care is family-focused.   The State must devote sufficient resources to wrap-around

services if it hopes to comply with State law and ASFA regarding the mandate to prevent the unnecessary or premature removal of children from their families to achieve genuine permanency. Similarly, wrap-around services will help DCYF to implement reunification plans for children temporarily separated from their families.

Medicaid Services (RIte Care, EPSDT, CEDARR)

The following DHS representatives provided expert assistance and information to the subcommittee: John Young, Richard Jacobsen, Joan Obara, Murray Brown and Trisha Leddy.

I. Current Reality

A. RIte Care is Medicaid's managed care insurance program for families on the Family Independence Program and eligible uninsured pregnant women, parents, and children up to age 19. Eligibility is based on family income and size. The program provides recipients with comprehensive health care through participating health plans. In FY 2000, nearly two-thirds of the more than 95,000 family members participating in RIte Care were children. Under RIte Care, access to prenatal care and maternal health in Rhode Island has improved. The average monthly cost per member was $159, which includes various wrap-around services. For children with special health care needs, the cost was significantly higher ($991 average per month) to provide home and community-based services. In FY 2000, an average of 5,437 children per month receiving Title IV-E services were enrolled in Medicaid, with a noted increase in spending on behavioral health services. Of DCYF-involved children receiving Title IV-E services covered by Medicaid, 52 percent were in substitute care (foster care) and 48 percent were in subsidized adoption. Children in DCYF care accounted for $79.8 million in a combination of State and Federal funds under the Medicaid program. In early FY 2001, foster children began voluntary enrollment in RIte Care health plans, taking advantage of a more coordinated system of health care among DCYF, health care providers, health plans and DHS. From 1997 to 1999, 4.8 percent of the State's low-income children under 19 years of age were without health insurance; however, all children in foster care are enrolled in a government-funded health care program. Incarcerated, sentenced children are not Medicaid eligible.

B. The Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) Family Centers were created in FY 2000 to help improve care for children with special health care needs. It is a project that provides a family-centered, comprehensive source of information, clinical expertise, connection to community supports and assistance to aid families in meeting the previously unmet needs of Medicaid-enrolled children with special health care needs, i.e., physical, developmental and mental disabilities. The CEDARR Initiative reflects a major commitment and level of coordination from DCYF and DHS, in collaboration with the Department of Health, the Department of Education, and the Department of Mental Health, Retardation and Hospitals.

The CEDARR Initiative has lead to a collaborative effort among DHS, RIDE and the LEAs to examine the level of services provided to these children in schools,

and to expand the level of federal reimbursement available for mandated school-based special education and health activities. Thus, LEAs may now claim reimbursement for the preparation of IEPs for Medicaid-eligible special education students.

The goal of the CEDARR Initiative is to serve 10,000 eligible clients. Service delivery began in April 2001.

C. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. In addition, the Social Security Act requires that any medically necessary health care service be provided to an EPSDT recipient even if the service is not available under the State' Medicaid plan.

The EPSDT program can cover certain services provided via CEDARR, on a case-by-case basis.

II. Solutions

A. Subsequent to the Supreme Court's decision in *Olmstead v. L.C.,* the State should re-evaluate the length of time children with disabilities spend in institutional settings and the efforts made to place children with disabilities in the least restrictive, most family-like setting possible.

B. Once available data is analyzed, the State should continue to examine improvement strategies to include DCYF and health plan providers in order to negotiate non-acute contracted days for service with all relevant agencies, institutions, departments, and private and/or public funders that will best meet the needs of DCYF population.

C. To assure both the provision of appropriate health care and the maximization of Juvenile Justice funding, the State should explore Medicaid services for adjudicated youth and detained, non-adjudicated youth.

D. The State should explore the following recommendations to address the funding problem often associated with the psychiatric hospitalization of DCYF children:

1. To have a third-party liability assessment at the time of admission;

2. To have a review of the discharge date and plan at the time of admission;

3. To require that private insurance be exhausted (and/or denied) with family and community providers before relevant Medicaid is determined and financial responsibility is transferred;

4. To have the State pay only what the private insurers would have to pay for in-patient psychiatric hospital days (The State should not pay higher rates than insurance carriers for the same service.);

5. To use EPSDT as a means to transition youth from psychiatric hospitalization to a gradual step-down program or an alternative to psychiatric hospitalization;

6. To examine RIte Care eligible children with a serious mental illness who have been carved out of RIte Care to determine how medical benefits can be better coordinated and utilized.

E. Regarding CIS, expand it and allow for a more flexible, long-term program; build up other parts of the system of care; expand prevention services (such as CES); expand Family Support Services; and explore Medicaid eligibility to fund expanded services.

Education Issues

Virginia daMota, representing the Rhode Island Department of Education, provided expert assistance and information to the subcommittee.

I. Current Reality

A. When children first enter DCYF placement system of care, the Family Court inquires as to whether DCYF should be appointed Educational Guardian of the child. The Family Court has authority to make this appointment and to determine the residency of the parents for purposes of allowing school districts to bill the responsible district for the education costs expended for children in shelters, group homes and other facilities. DCYF is responsible for assuring that children are enrolled in appropriate educational programs immediately upon entering substitute care. In order to help facilitate a smooth transition from one system of school to another, DCYF provides the school with the child's "Intrastate Educational Identification Card."

1. Family visitation plans and counseling appointments arranged by DCYF do not always accommodate a child's school day and commitment to school-related activities.

2. Shelter and group home providers often report that they experience resistance and unnecessary bureaucratic demands from schools when enrolling DCYF-involved youth.

3. When children experience multiple and/or frequent moves from one placement to another, their academic progress is interrupted and gaps in their education develop. It is common among youth who spend a significant amount of time roaming around the placement system to be 2 or 3 years behind their peers in their education; many leave the system without a high school diploma. Too many youth do not pursue an advanced degree.

4. When children are forced to endure the night-to-night placement system, their education is in abeyance. This has had a disproportionate impact on adolescent girls, who are more highly represented among the night-to-night

population than boys. (The Second Amended Consent Decree entered 8/27/01 addresses this issue.)

B. DCYF-involved children with special education needs are entitled to appropriate educational services under IDEA. When children with disabilities do not have a parent or guardian able to act on educational matters for them, DCYF caseworkers refer children to the Educational Surrogate Parent Program, operated by the Office of the Child Advocate and supported by RIDE. The Program appoints professional Educational Surrogates to assure that children have appropriate evaluations and IEPs, are educated in the least restrictive setting possible, and to the extent possible, are placed with children who do not have disabilities. Approximately 1200 children, including many youth at the Training School, are represented annually by Educational Surrogates. The Program provides consistent and zealous representation of children who require educational advocacy. Approximately 1000 of these children are deemed "high need."

C. Children placed by DCYF in a residential facility and who attend the facility-operated school have their educational expenses incorporated in the total placement cost paid by DCYF to that facility (these facilities include ACE, Alternatives, Cam E-Hun-Tee, Ocean Tides and the Rhode Island Training School for Youth). The Rhode Island Training School has and continues to experience significant and frequent problems with their educational program, especially for girls.

D. Barriers exist for youth transitioning from the Training School to schools within the community.

E. The school suspension rate for DCYF-involved youth, especially black males, appears to be higher than it is for other populations of children.

F. System-wide coordination between schools and community-based programs is lacking. Outreach and Tracking, such as the TIDES Program, are Medicaid eligible; yet the State has not fully explored alternative funding sources for additional community-based services which would work closely with schools.

G. The Parent Support Network (PSN) and the Rhode Island Parent Information Network (RIPIN) provide education, referral, support and advocacy services to parents on a variety of education-related issuess.

III. Solutions

A. The process for school enrollment of DCYF-involved children, and the delays that often accompany the process, need to be addressed through the promulgation of regulations and/or the passage of legislation by the General Assembly with input from DCYF, RIDE and local school districts. Further, when children are physically placed outside their existing school district once an academic year has begun, they should be allowed to complete school in the home district for at least the remainder of the year if it is in their best interest to do so.

B. DCYF, via the RFP process, should require vendors to cooperate with CASSP. The Department should encourage the formation of a bridge between school districts and community organizations. Financial incentives and/or CASSP and respite services could be offered.

C. To address barriers for youth transitioning from the Training School to community-based schools, Project Hope should be implemented system-wide as a model for all school districts.

D. The legislature and DCYF should closely examine racial bias in the schools and the suspension rate of DCYF-involved children. In-school vs. in-home suspensions should be the subject of an in-depth discussion among all interested parties.

E. To reduce disruptions in a child's education, the State should examine the use of Mental Health Centers for diagnostic assessments and pre-screening evaluations. Before managed care, these assessments and pre-screenings helped reduce reliance on psychiatric hospitalization for children. This initiative could encourage the use of a network of services for children within the community, rather than withdrawing them from the community and their school.

Juvenile Justice: Probation, Diversion and Community-Based Services

Mike Burk, representing DCYF, Brother Michael Reis, Executive Director of Tides, and David Heden, representing the Family Court, provided expert assistance and information to the subcommittee. Data reviewed included the 1997 JJTF Report and Family Court juvenile statistical reports.

I. **Current Reality**

A. Family Court juvenile statistics show that during the year 2000, a total of 8,672 offenses were committed by youth within the State, broken-down as follows: violent crime-492; assaults-1,013; property crimes-2,606; motor vehicle violations-515; status offenses-1,093; truancy-461; weapon offenses-205; drug/alcohol-927; disorderly conduct-1,016; miscellaneous-344. The five core cities – Providence, Central Falls/Pawtucket, Newport, West Warwick, Woonsocket – yield most of the juvenile-related problems. A high percentage of the total number of offenses – 24.45 % -- were committed by youth residing in Providence. In addition, there were 1,280 violations of probation, 29.30 % of which were committed by Providence youth.

B. Each of the five core cities has developed a comprehensive prevention strategy to mobilize and coordinate all community-based resources. However, cities lack funding sources to fully implement the plans and they often compete for scarce resources.

C. Funds have been approved for a new juvenile corrections facility. This facility, among other things, is meant to provide better supervision of and programming for incarcerated youth.

D. Project Hope is operational in 4 catchmen areas. It consists of graduated sanctions and goal-based sentencing, with developmental assistance from the National Center on Crime and Delinquency. It has enhanced DCYF's capacity to deliver mental health, substance abuse and other medical treatment, via Lifespan, for the population served.

E. The Office of the Attorney General is leading efforts to pass legislation related to gun ownership.

F.   "Safe Streets" is a Providence-based collaborative program among DCYF, the Providence Police Department, the Adult Correctional Institution, Adult and Juvenile Probation.

G. Misbehaving children move too quickly from their communities to the State system of care, i.e., the Training School or DCYF's care and supervision, in order to access services but often without considering the severity of the offense and the circumstances of each child. Local communities have too few community-based interventions and/or sanction options to address the problems these children pose.

H. After-school programming exists in all Providence middle schools for at-risk youth up to age 15.

I. Tides Family Services reaches many troubled youth via its Outreach and Tracking programs in Pawtucket/Central Falls and West Warwick. It has begun to expand programming into Providence. Nevertheless, there is a lack of outreach and tracking, and diversion programs

J. The Truancy Court has dealt with approximately 200 children, only 12 of which have been referred to DCYF.

II. **Solutions**

A.   "Safe Streets" should be expanded to other cities and communities. Outreach and Tracking programs should be expanded throughout the State, especially in Newport and Woonsocket.

B. DCYF and other appropriate agencies and departments should assure that reasonable, effective and creative efforts are made to address the behavior of troubled youth within their own communities. Thus, DCYF should assure a system of graduated sanctions correlated to the severity of youths' unacceptable behavior.   The   subcommittee   strongly   supports   the   conclusions   and recommendations of the Governor's Task Force on Juvenile Justice Reform (see JJTF Report, Executive Summary, dated July 1997), particularly recommendations 1 through 11.

C. DCYF should increase and improve its ability to conduct research for multiple reasons, including the need to utilize research-based data to more effectively plan on a short- and long-term basis.

D.   After-school programs should be expanded. They should provide an array services, including tutoring and help for children with disabilities.

E.   Individual schools should be accountable for addressing the particular needs of their enrolled children in order to help them succeed beginning with kindergarten and continuing through high-school. Truancy and school-failure are the gateways to juvenile waywardness and delinquency. Therefore, genuine efforts should be made by all school personnel to prevent truancy and school failure by closely monitoring the status of at-risk children and bringing together a myriad of service providers and family members to communicate about and plan for these children as soon as signs of trouble are identified.

F.   School-based outreach to children with problems should be better organized, more consistent and individualized in order to respond to the specific problems of children and their families. In addition, schools should enter into partnerships with other community-based service providers to assure coordination, cooperation and communication regarding what is best for that community's children.

G.   Cultural sensitivity must be a major component in school and community-based plans to serve children and their families.

H.   Colleges and universities within the State with formal teacher-training programs should incorporate within their education curriculum for future teachers relevant information about and exposure to communities with high concentrations of families that are poor, bilingual and/or racially diverse. The Central Falls Professional Development School, a joint venture with Rhode Island College, was noted as a potential model for cultivating awareness of issues germane to inner-city school children among prospective teachers.

I.   Youth transitioning from out-of-state placement or the Training School should be encouraged and allowed to integrate into the community and local school district. Community service providers and leaders should rally behind these youth.

J.   Early intervention services to meet the needs of families, particularly those with elementary- and middle-school-aged children, should adopt policies and procedures that emphasize the importance of collaboration with other service providers and schools.

K.   The Truancy Court model that has been successful in several communities should be expanded as a state-wide initiative to meet the individual needs of children. It should operate in alliance with RIDE, DCYF, Family Court, local school districts, community service providers and families.

L.   All State RFP contracts should encourage service providers to cooperate with schools and community organizations, and to develop partnerships and collaborative agreements as necessary.

M.   The Rhode Island Department of Education (RIDE) has identified approximately 19 alternative education programs within the State that lacked regulatory

oversight. Other recently identified problems include a shortage of qualified teachers and too many teachers with emergency certification. Oversight efforts should be tightened to avoid similar problems in the future.

Legal Services

Legal agencies provided information via a Survey submitted to them from the subcommittee.

I.   Current Reality

A. Court Appointed Special Advocate (CASA), under the auspices of the Family Court. A state-wide system of attorney Guardian *ad litems* who work with social caseworkers and volunteers to represent individual children involved with DCYF by advocating a course of action that is in their best interest.

   1. Population served: approximately 3,000 children up to age 21.

   2. Eligibility: all children for whom a child protective petition, alleging parental dependency, neglect or abuse, are filed in the Family Court.

   3. Staffing: 11 attorneys, 1 project manager, 5 social caseworkers, 1 volunteer recruiter, 1 volunteer coordinator, 2 data entry aides.

   4. Annual budget: $1,472,680, 12.55 % of Family Court budget.

   5. System of care problems: night-to-night placement; lack of step-down placements from hospitalization; shortage of foster homes, particularly therapeutic foster homes; separation of sibling groups; disruptions in education; lack of in-state residential facilities; lack of aftercare from the Training School; too many youth "age-out" of the system ill-prepared for independence; more specialized training for DCYF workers on adoption-related issues.

B. Office of the Child Advocate (OCA): advocates for particular children whose legal, civil and special rights in DCYF system and/or Family Court proceedings are not being met. In addition, the Office advocates for a group of individuals as an identifiable class where system change for an entire class is necessary.

   1. Population served: children in the care of DCYF.

   2. Eligibility: Children under the care of DCYF or matters relating to DCYF, including child care, foster care, residential programs, group home, mental health services for children and the Training School.

   3. Staffing: Attorneys, social workers, educational advocates and clerical workers.

   4. Annual budget: $865,000: $523,165 state funds; $342,703 federal contract with RIDE and Medicaid monies; $23,000 VOCA grant.

5. System of care problems: lack of continuum of care within the placement system and lack of placement prevention efforts and resources.

C. RI Disability Law Center:

1. Population served: Free legal assistance to adults, youth and children with disabilities.

2. Eligibility: Callers requesting legal assistance are referred to one of two intake advocates.

3. Staffing: Director, 2 attorneys, 2 legal advocates, 2 intake advocates, finance/office director, 1 secretary/receptionist.

4. Annual budget: $1,000,000, DHHS, DOE, and Social Security.

5. System of care problems: lack of continuum of mental health care, with emphasis on community treatment options.

D. Office of the Public Defender:

1. Population served: Legal services to parents and juveniles with matters before the Family Court who meet financial criteria.

2. Staffing: 4 attorneys in the Parental Rights Unit and 5 attorneys in the Juvenile Unit.

3. Funding from the State of Rhode Island.

4. System of care problems: lack of placements of all types for children.

II.   Solutions

A. Continuing education and training on a variety of topics needs to be provided to attorneys working within the system of care to help them stay abreast of the latest research and data regarding issues germane to child welfare, and exemplary standards of child welfare legal and social work practice. New attorneys should be provided with experienced mentors.

B. Attorneys working within the system of care should adapt to positive changes in law, policy and practice within the system (for example, the concept of Concurrent Planning), rather than adopt a cynical view from the outset.

APPENDIX N: GENDER-SPECIFIC PROGRAMMING FOR FEMALES ALONG RHODE ISLAND'S SYSTEM OF CARE

DEFINITION: GENDER-SPECIFIC PROGRAMMING

Gender-specific programs are ones that intentionally allow gender identity and development to affect and guide program design and service delivery. Gender-specific programming specifically refers to unique program models and services that address the specific needs of a targeted gender group. An essential ingredient is the fostering of positive gender identity development (Maniglia, R. and The Peters Group).

DEFINITION: GENDER-SPECIFIC PROGRAMMING FOR FEMALES

Gender-specific programs for females are comprehensive, providing services along a continuum of care. Programs are designed to recognize the risks and dangers females face because of gender, especially a history of abuse or other forms of victimization. They encourage resiliency factors and life skills that help girls make a positive transition to womanhood and prevent future delinquency. (Office of Juvenile Justice and Delinquency Prevention, 1998)

RATIONALE

While gender-specific programming applies to specialized programming for either males or females, there is currently a national focus on gender-specific programming for females because females' involvement in the system, particularly the court system, has been escalating at unprecedented rates and program models and intervention modalities have been geared toward the needs of a predominantly male population. This is a circumstance that requires an immediate systemic response, however it does not negate the possibility of exploring optimal programming modalities for males in the future.

Until recently, research on patterns of delinquency and recidivism within the juvenile justice system was conducted mostly on males, and research on the etiology and the treatment needs of juvenile offenders focused solely on males as well (Odem & Schlossman, 1991; Chesney-Lind, 1986; 1989; Shelden, 1998). Though juvenile delinquency has been viewed historically as a "male problem," statistics on juvenile delinquency reveal that rates of female delinquency are on the rise (Greene, Peters, & Associates, 1998) and that young girls are becoming court-involved at greater, unprecedented rates. Between 1992 and 1996 juvenile female delinquency increased 25% nationally while juvenile male delinquency remained steady. Recent studies reveal that there is a significant lack of program options tailored to meet the unique needs of a female population.

REVIEW OF IMPORTANT RESEARCH FINDINGS

In order to develop and implement effective programs for at-risk females and female offenders, policymakers, administrators, managers, staff, and community providers and advocates must be familiar with a core body of well-documented research regarding:

1. Female psychosocial development (including the impacts of socialization, girls' relational orientation, and girls' unique decision-making processes and motivators), and

2. Unique factors that place young women at risk of involvement in the child welfare and juvenile justice systems, as well as their unique pathways into such systems

Female Psychosocial Development

Research has evinced developmental differences in males and females and distinct variations in the way they see and understand the world. Cutting-edge scholarship regarding female development has revealed that females have a relational orientation to the world and focus on connection with others. Armed with a more detailed and accurate picture of how females develop, new research is replacing outdated studies that came to wrongful conclusions about female moral, psychological, and social development (Caplan & Caplan, Gilligan, C., Jordan). Research continues to show the negative aspects of socialization and their particular effects on girls and young women. Socially determined gender roles and male/female stereotypes can be limiting and damaging, and objectification, abuse, harassment, and extensive family responsibilities are now being understood as major themes in the lives of girls and women (Chesney-Lind, 1997, OJJDP 1998). Programming must incorporate these themes so that girls and young women can learn how to deal effectively with the issues that impact their lives and choices and services can effectively reach this population.

Female Risk Factors for System-Involvement

Abuse and Exploitation

Girls and young women are sexually abused almost three times more often than boys (Sedlack & Broadhurst, 1996). Girls and young women who have been sexually abused are more likely to have high stress, depressive symptoms, and low self-esteem. The prevalence of abuse in the lives of girls and young women points to the need for services that directly address issues of victimization and survival.

 "The abuse and exploitation of young girls should be viewed as a major and pervasive public health threat and a primary precursor to involvement in the criminal justice system" (OJP Coordination Group on Women, 1998). "Girls need access to a continuum of placement options in which their safety can be ensured while they address the issues that brought them into the system and receive the services they will need to leave it (OJP Coordination Group on Women, 1998)." Such options should be non-punitive.

❑ 8 million, or 1 out of every 4 girls are sexually abused before the age of 18 (CWF, various national statistics)

❑ Girls are much more likely than boys to be victims of sexual abuse, especially family-related abuse (Chesney-Lind and Sheldon)

❑ The incidence of physical and sexual abuse and/or exploitation among court-involved girls vary from a low of 40% to a high of 73% and as high as 95-100% of girls in residential and training school facilities) (Chesney-Lind and Sheldon)

❑ Abuse is the primary cause of running away from home, a status offense that is often a girls' first involvement with the juvenile justice system

❑ Sexually abused runaways are more likely to engage in delinquent activities (e.g. substance abuse, theft, and prostitution) (Chesney-Lind and Sheldon)

❑ Most girls seek help from the consequences rather than the causes of abuse (Chesney-Lind, 1995)

❑ Studies confirm that abused children are at high risk for subsequent involvement in delinquency and violent behavior (Widom, 1992; Thornberry, 1994)

Substance Abuse

Another important risk factor for females is substance abuse. Recent studies have revealed that girls and women have different substance abuse patterns and motivations for substance use than their male counterparts. In the realm of corrections, it is now known that drug abuse is a greater problem for female offenders than for male offenders. The American Correctional Association found that girls have higher rates of substance abuse and addiction - 60% of girls in state training schools in the juvenile justice system need substance abuse treatment at intake and over half of those are multiply addicted (American Correctional Association, 1990). Researchers and practitioners who work with girls and women are beginning to acknowledge the relationship between trauma and substance abuse and a number of studies have found a correlation between chemical dependency and physical and/or sexual abuse, especially among females. In many cases, substance abuse among many at-risk and court-involved girls is effectively numbs the pain from past and/or continuing abuse.

❑ Studies indicate that at-risk girls indicate that drugs allow them to escape emotional pain from abuse

❑ Over time, drug usage can become a problem or cause other problems such as addiction and the attendant behavior necessary to attain drugs by any possible means, including criminal activities

❑ A national survey of female juvenile offenders in training schools discovered that the typical female juvenile offender "started using alcohol or drugs between the ages of 12 and 15 (ACA, 1990). 64% used alcohol at least once or twice a week. Of the 59% who used cocaine, 47% did so on a daily basis. Of the 78% who used marijuana, 47% did so on a daily basis (ACA, 1990)

❑ There is a long known link between drug use and sexual activity (Bergsmann, 1994).

Teen Pregnancy and Parenthood

Teenage pregnancy and parenthood is also a "major delinquency risk factor" for female juvenile offenders and teenage girls in general (OJP Coordination Group on Women, 1998). Many females who enter the court system are pregnant or are mothers, and the system lacks program options to meet their needs (The Peters Group, 1998).

❑ In 1995, teenage girls represented a third of all unmarried mothers in the country (Adams, et al. 1995)

❑ Girls often trade sex for love (Chassler, 1997)

❑ Research indicates that girls get pregnant "to feel needed and/or loved unconditionally", to have "someone to love and care for and call [their] own"; to keep a boyfriend, to obtain love and popularity, and to escape from an abusive living situation (Chassler, 1997).

❑ Most female juvenile offenders see pregnancy as a response to past sexual victimization (Chassler, 1997).

Low or Damaged Self-esteem

Low self-esteem is another major risk factor for girls' system-involvement. The breakdown of girls' families and emotional, physical, and sexual abuse cause feelings of profound rejection.

❑ The majority of female juvenile offenders are victims of severely dysfunctional families and have suffered from neglect and violence and are often emotionally distressed and have limited or no self-respect (OJP Coordination Group on Women, 1998).

❑ Self-reported data show that more than half of young women in training schools have attempted suicide and 64% of them have tried more than once (ACA).

❑ Feelings of poor self-esteem are mirrored in the larger society among teenage girls as evidenced by a growing body of research in this area (Chesney-Lind and Shelden)

Truancy and School Dropout

Truancy is a major precursor to court-involvement for girls. Indeed, many girls first enter the court system for truancy and other status offenses (The Peters Group, 1998; Chesney-Lind; Chesney-Lind & Shelden).

❑ The typical female juvenile offender is a high school dropout (The Peters Group)

❑ In 1990, the American Correctional Association found that 27% of girls dropped out of school because of pregnancy and 20% left school to be full-time mothers (ACA)

❑ In a national study of girls in training schools, 65% had completed only 1 to 3 years of high school and had not received a general equivalency diploma (GED). Of these

girls, 36% did not return to any type of school after leaving the training school (ACA).

❑ When girls leave school, they are less likely to return. This is related to their relational orientation to the world and their damaged self-esteem. Girls who leave school feel marginalized and lose essential connections with peers and staff. They also feel unprepared and fear failure upon return.

Lack of Appropriate Intervention and Re-victimization by the Court and Child Welfare Systems

There is a lack of appropriate prevention and intervention programs for girls (The Peters Group, 1998; OJJDP). Because of this, girls who enter the system often do not get essential needs met. The pervasive lack of information on girls' unique pathways into the system and unique needs often translates into their behaviors being viewed and responded to in isolation. Girls' abuse and trauma histories are often unknown and thus ignored. Ultimately, girls return to the court system repeatedly and move from program to program, in a system designed to meet the needs of a mostly male population. The structure of many programs does not allow for essential gender-specific programming components. Finally, research also indicates that females tend to be punished more severely than their male counterparts, and are often detained or placed in secure settings for protective reasons.

❑ In a 1996 study of incarcerated women in California, Connecticut, and Florida, a significant proportion of women reported that they had been in trouble as girls and yet little or nothing had been done to help them.

❑ Nearly half of the women had been suspended from school, more than half ran away from home, often to escape abuse.

❑ Nearly 30% began as status offenders

❑ Most reported having experienced one or more forms of abuse

Assumptions of Gender-specific Programming for Females

(Adapted from Maniglia, R.)

❑ Gender-specific programming does not exist simply because a program has an all-female (or all-male) clientele.

❑ Gender-specific programming does not exist simply because a program has been in the girl-serving (or boy-serving) business for a long time.

❑ Girls have different aspects to their development than boys, so services and interventions need to be different.

❑ Equality is not about providing the same opportunities for girls and boys, but about providing opportunities that mean the same to girls and boys.

❑ Good gender-specific services begin with good services (e.g. safety and security, well trained, responsive staff, ongoing evaluation of program policies and components, supportive administration).

Principles of Gender-specific Programming for Females

(not a complete list)

1. Gender-based programming, or, space that is physically and emotionally safe and separate from male programming space

2. Opportunities for girls to discuss their lives and personal strengths and challenges without the distraction or demands for attention of male youth

3. Education about women's health, including female development and sexuality

4. Mentors who share experiences that resonate with the realities of girls' lives and who exemplify survival and growth

5. Opportunities for girls to understand women's history and girls' roles in shaping history

6. Opportunities for girls to understand their culture and appreciate and respect the cultures of others

7. Opportunities to learn how to develop and maintain healthy relationships

8. Opportunities for empowerment and self growth beyond the experience of victimization

9. Psychotherapeutic opportunities and mental health treatment

10. Access to female staff members

11. Single-sex programming and recreational opportunities (in co-educational programs)

12. Adequate funding for providing comprehensive programming across the continuum of care

The concept of gender-specific programming is grounded in sound theoretical and practical research on female development and the unique risk profile shared by girls and women, particularly those that are court-involved. Gender-specific programming strengthens the foundation of programs and services for court-involved girls. To meet the specific needs of girls and young women and provide them with best practice services, a gender-specific model of treatment and intervention is critical.

Implementing Gender-specific Programming for Girls in the Rhode Island Juvenile Justice System

Historically, the overall number of girls and young women involved with the juvenile justice system across the nation has been small compared to that of boys and young men. Because girls and young women have not dominated the system in raw numbers, program

options have not been tailored to correspond to their needs as a subgroup, and both locally and nationally there is a paucity of program options tailored to meet their unique needs. Without programming and services that are attentive to their risk profile, girls and young women will continue to enter and re-enter the court system at alarming rates.

The Federal Mandate to Implement Gender-specific Programming for Females

In recent years, the rising numbers of girls and young women entering and re-entering the court system has stimulated national concern regarding the availability of services for females and the effectiveness of programs serving females.   During the 1992 Reauthorization of the Juvenile Justice and Delinquency Prevention Act of 1974, Congress paid close attention to the concerns brought by researchers and youth-serving professionals in which they expressed and identified a necessity to address the gender-specific needs of girls and young women. This was accomplished through Congress' references to and emphasis on importance of equity and gender-specific services throughout the Reauthorization legislation. The final Act outlined three specific areas in which states were required to respond and take action. It required each state to:

❑ Conduct an analysis of gender-specific services for the prevention and treatment of juvenile delinquency, including the types of such services available and the need for such services for females;

❑ Develop a plan for providing needed gender-specific services for the prevention and treatment of juvenile delinquency; and

❑ Provide assurance that youth in the juvenile justice system are treated equitably on the basis of gender, race, family income, and mentally, emotionally, or physically handicapping conditions.

These provisions recognized the Act's previous failure to deal with gender bias in a meaningful way and provided the impetus for states to begin to look more closely at the girls and young women moving through their juvenile justice systems. Several states, including Rhode Island, have begun to proactively address these issues within their juvenile justice systems.

New research and national best practices have provided a foundation of knowledge that is allowing researchers, practitioners, administrators, and policy makers to understand the utility of effective service delivery for girls in the context of goals to reduce court-involvement and recidivism. Research has shown that girls in the juvenile justice system are more likely than boys to be victims of abuse, to enter the system with status offenses, and be sanctioned to programs that serve more serious, male offenders. Since girls exhibit specific behaviors that are unique to their gender, they require different interventions, sanctions and services. The majority of juvenile justice providers nationwide lack the skills, tools, and resources necessary to be effective in providing a framework for girls to be successful in changing negative behaviors.

Strengthening Services for Girls and Young Women Along the Continuum of Care

The concept of gender-specific programming is grounded in sound theoretical and practical research on female development and the unique risk profile shared by girls and

women.   The principles of gender-specific programming should exist at the core of service delivery in juvenile corrections, foster care, behavioral and mental health, and substance abuse intervention and treatment. Gender-specific programming will strengthen the foundation of services for girls and young women throughout the continuum of care.   The systemic change that has begun to take place in the juvenile justice must be replicated in other systems. To meet the specific needs of girls and young women and provide them with best practice services in their communities, a gender-specific model of treatment and intervention is critical. In conjunction with the juvenile justice system, other human welfare, protection, and rehabilitative systems have the opportunity to join efforts and resources to build a veritable and nationally recognized gender-specific service delivery network that provides quality care for all youth receiving state services.